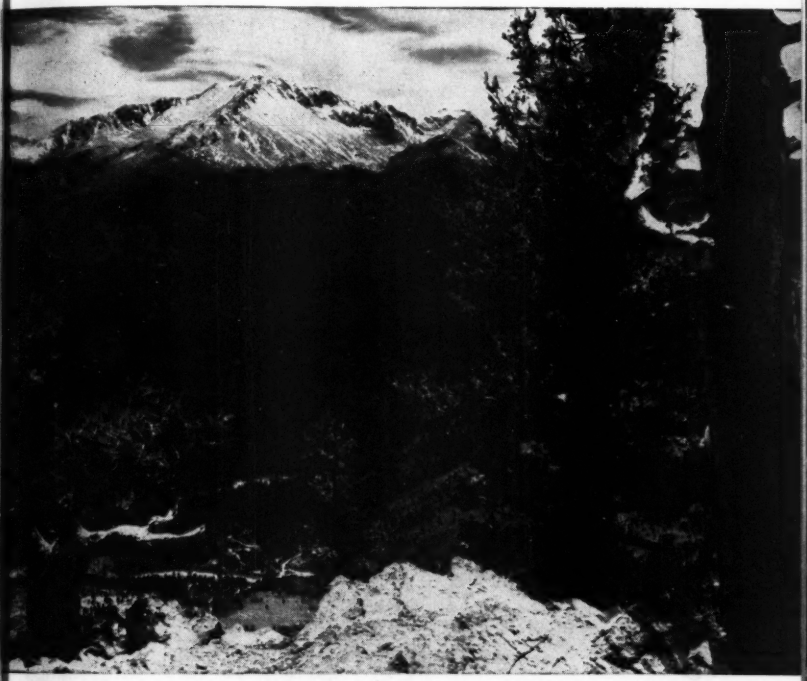
Oral Hygiene

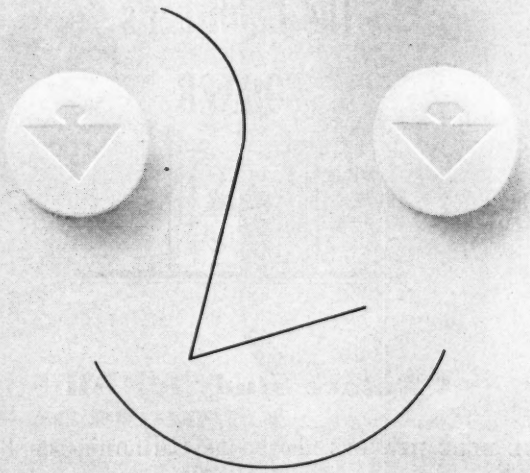
AUGUST 1954



Pikes Peak viewed from Chipita Point near Colorado Springs, Colorado. The Colorado State Dental Association will hold its annual meeting in Colorado Springs October 3 to 6.

In this issue:

GROUP PRACTICE . . .
AN APPROACH TO IDEAL DENTISTRY



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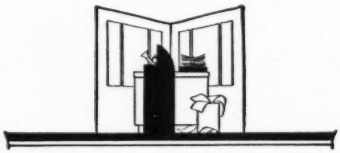
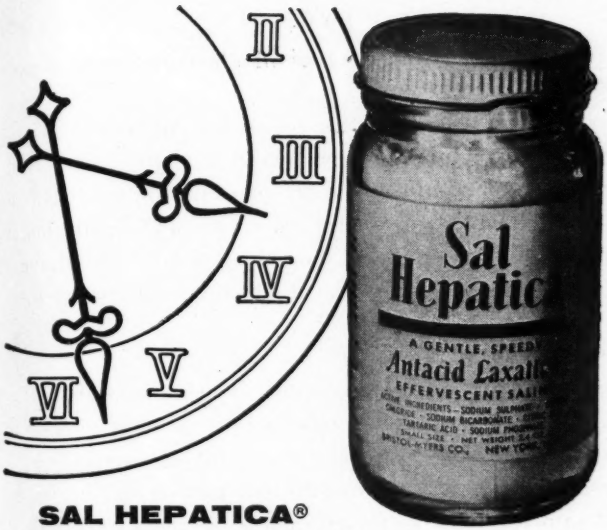


No. 397

Nature Study for All

IN THE BLUE HEAVENS above, the California sun hung high. Round about, the beauty of the Sierras was enchanting. The ancient loveliness of the old, old mountains was somehow fresh and new as a rose just blossoming. Birds now and then twittered in the trees. But, mostly, that day we were living in blessed silence.

Rodney trudged ahead through the thick carpet of fallen leaves. He had been quiet for a long time; finally he spoke. "I promised to teach you something about tarantulas. Well, here's an opportunity. There's a tarantula colony just below the surface of the ground around this big redwood." Rodney kneeled down. "Look!" he exclaimed as he scraped away some leaves. "Look!" And I did—I looked at a circular hole an inch or so in diameter into which a horrid hairy great big spidery thing was disappearing, squeezing his way into it somehow. "I'll show you in a minute," Rod promised. Then slowly, carefully, he went to work with his jackknife, peeling off a layer of top soil, a square foot



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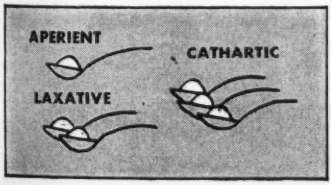
SAL HEPATICA'S Action Has a Sound Pharmacologic Basis

1. It is antacid and effervescent. Reduction of gastric acidity decreases emptying time of the stomach.[1]

Effervescent mixtures also shorten the emptying time.[2]

Thus SAL HEPATICA quickly leaves the stomach to enter the intestine where its laxative action takes place.



2. It stimulates intestinal peristalsis by its osmotic action. The fluid drawn into the intestine is a mechanical stimulus to evacuation, which usually follows promptly.

Prompt, gentle laxation without griping follows the use of pleasant-tasting SAL HEPATICA. The gastric hyperacidity so frequently accompanying constipation is relieved, too, because SAL HEPATICA is antacid.

References:

1. The Physiological Basis of Medical Practice, 1945, p. 486.
2. New England J. Med. 235:80, July 18, 1946.

ANTACID, EFFERVESCENT, SALINE LAXATIVE

BRISTOL-MYERS CO., 19 West 50 Street, New York 20, New York

or so of it. It was like lifting the roof off a house to see what goes on inside.

Plenty was going on in the little rooms and corridors, laid out as they were like a miniature ranch house. A dozen or so tarantulas raced about in confusion, some pausing now and then to glower at us. Then they calmed down a little and finally began to disappear through a hole in the colony floor. "They have a sort of rumpus room underneath," Rod said, "but I won't mess with it. Live and let live. Right?"

"Right," I said.

The architecture of the little ranch house was fascinating. There were even a couple of powder rooms, or what seemed to be powder rooms. The tiny walls especially astonished me. I asked Rod, "How come the hard, glistening covering?"

"Oh," said Rod, "that's the tarantulas' secret, I guess. They chew up some sort of mountain berry and then gargle it about a bit until the consistency is just right; then they plaster their little walls. See! You can't nick them with a knife."

"What's that tiny thing that looks like a rope, running through all the rooms?"

"Oh, that!" said Rod. "That's the intercom system. I forgot to mention it. Glad you brought it up. Nobody knows how they make the little rope or just what it is or how it works; but one scientist I met says there's no doubt about it being an intercom system. Nature is sure wonderful, ain't it?"

"But, Rod, how about food storage. I don't see any facilities for that."

"Simple," said Rod. "They don't need to store any food. You see, they eat each other—little by little, a leg here, a leg there. No storing food, no cooking—but we better hurry back to the cabin. The sun is going down and it will be getting dark. Tomorrow, I'll teach you more about tarantulas."

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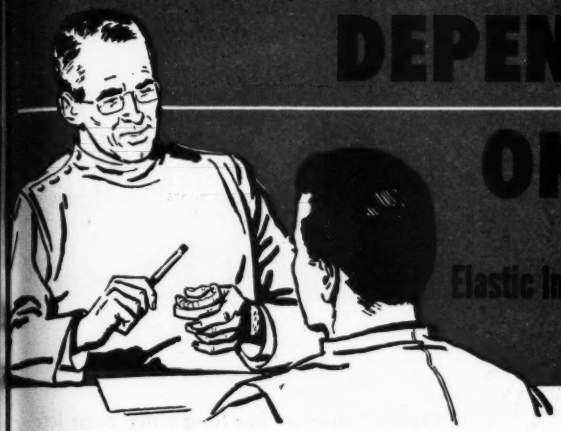

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"Oxcart" therapy has long since been left far behind by authoritative medical research which—in the field of dental analgesia—has resulted in the formulation of Poloris Poultice.

This modern scientific preparation employs the clinically-proven capsicum, to provide effective, gentle counterirritation, for gratifying pain relief and reparative tissue stimulation. Its action is enhanced by the local anesthetic, benzocaine.

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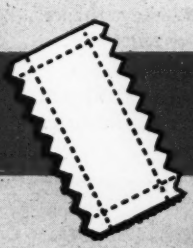

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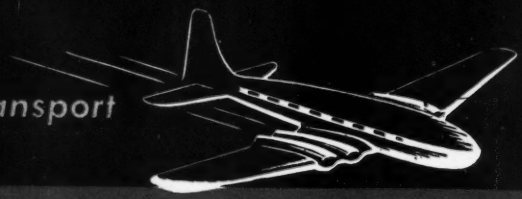

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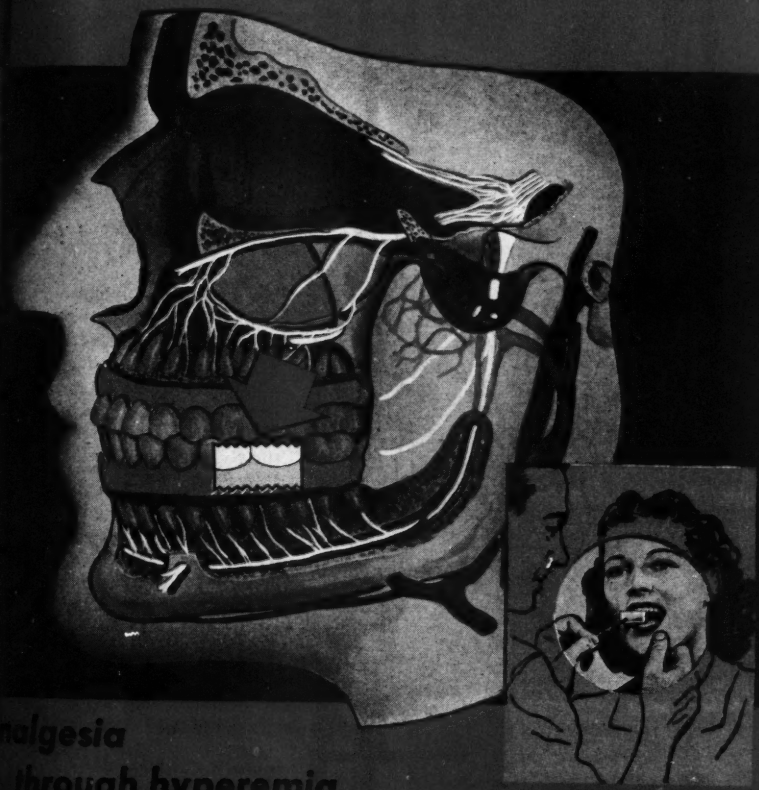

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Schaerrer, W. C., J. Missouri M. A., 37:287.

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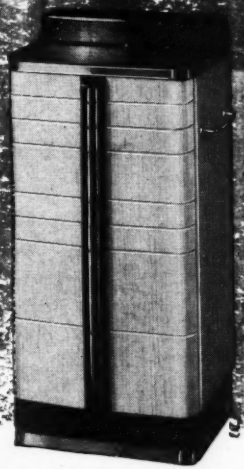

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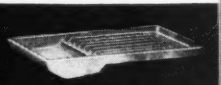
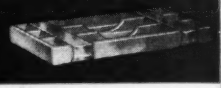
American Cabinet efficiency and service begin within the drawers—outfitted to meet the varying needs of every practice. A generous assortment of heavy white glass trays is provided with each cabinet—ranging from sixteen in compact, mobile Cabinet 201 (shown) to thirty-two in big, stationary Cabinet 170. Trays are 4″ x 8″ and are interchangeable—with rounded inside corners for easy cleaning and sterilizing, and molded bottoms to prevent wobbling. See these and the many other outstanding American Cabinet features at your dealer's—soon.

No. 16 Tray—eight grooves for long-handled instruments.

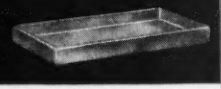


No. 17 Tray—three compartments for clamps and separators.

No. 18 Tray—especially designed for polishing strips, etc.



No. 19 Tray—one large compartment for root forceps, pliers, etc.



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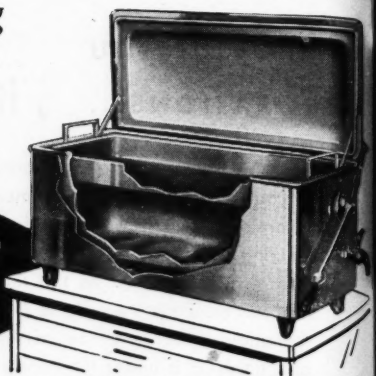

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● **DURABILITY AND LOW COST** — Lifetime service is built into these units by casting the body of the sterilizer in one smooth piece of high-grade bronze. The exterior is fabricated of gleaming stainless steel which provides both pleasing appearance and strength. This durability means trouble-free service at low cost over the years.

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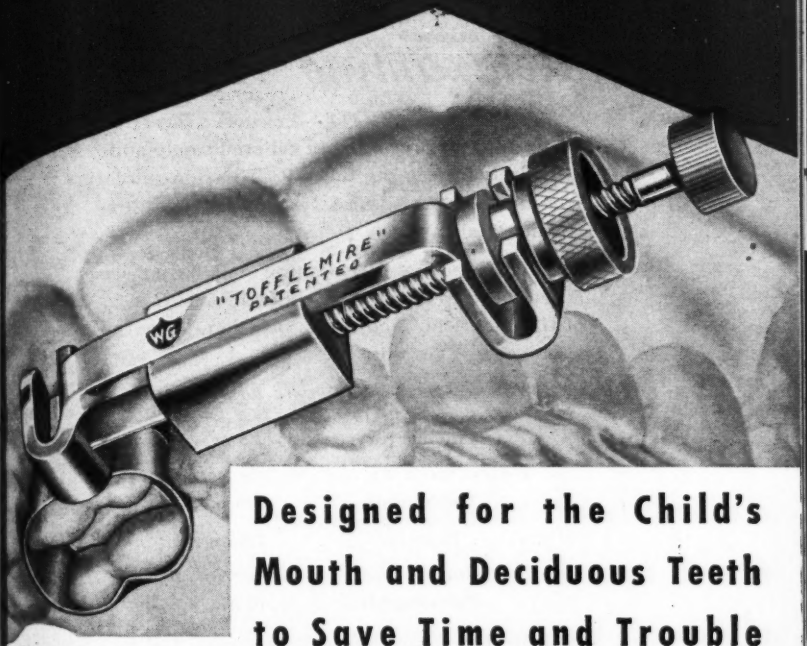

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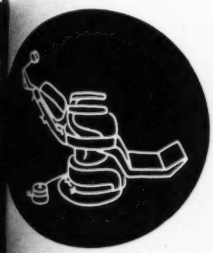

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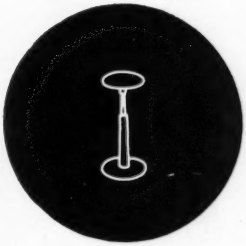

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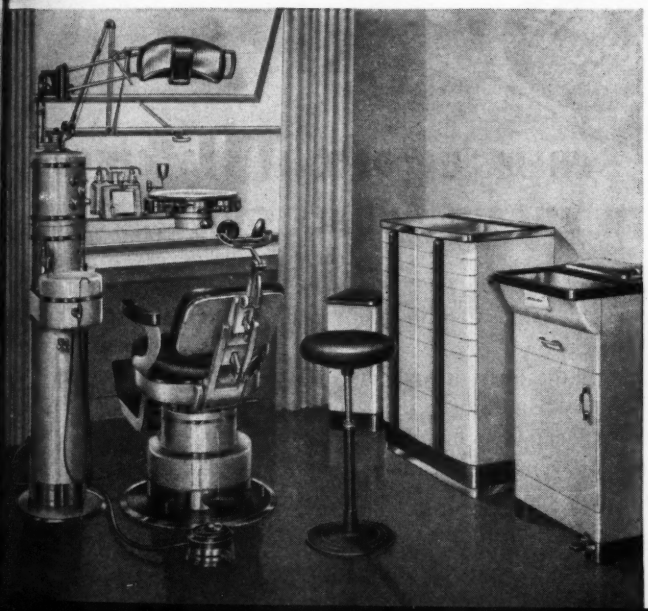

S. S. White
Master Unit D-2
Motor Chair
and
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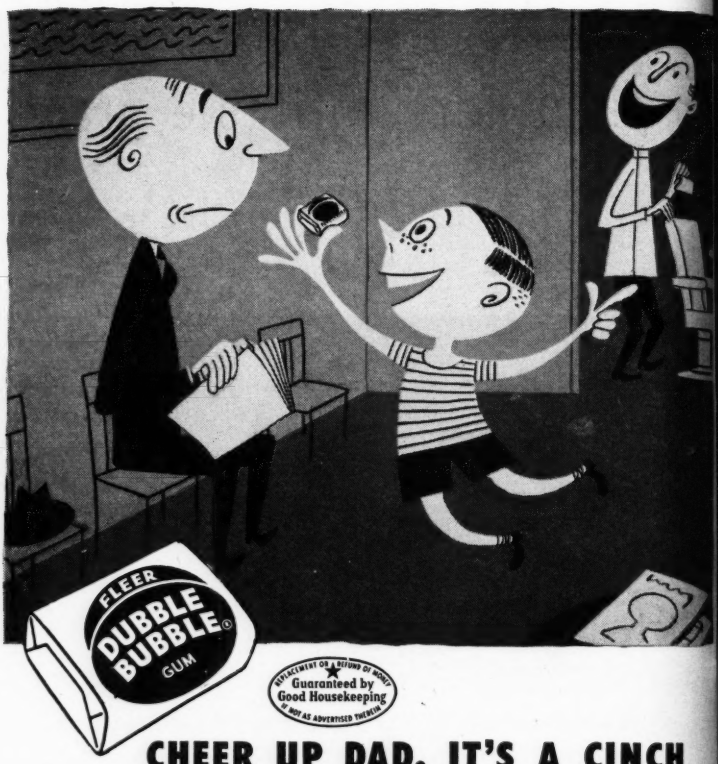

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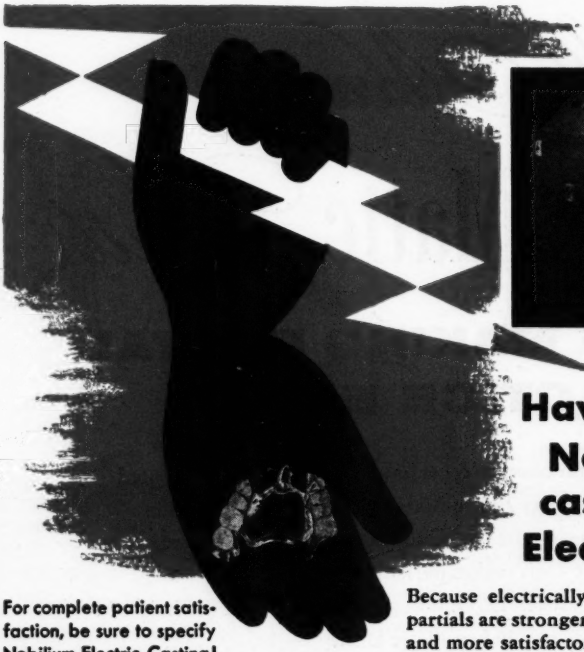

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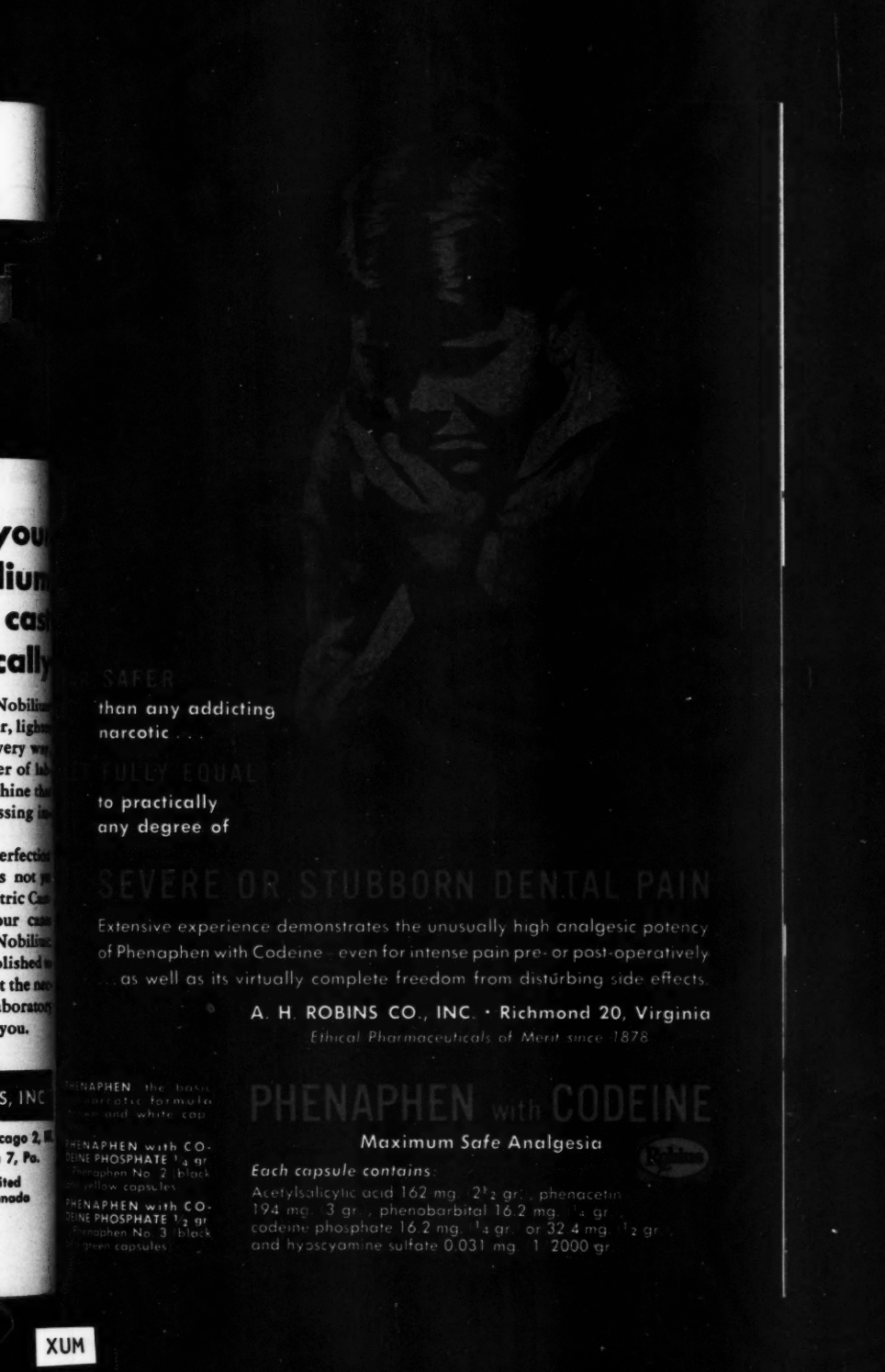
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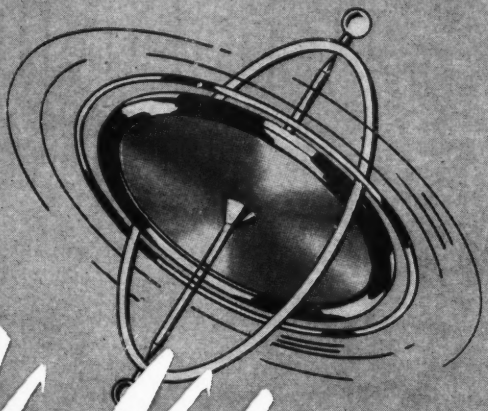

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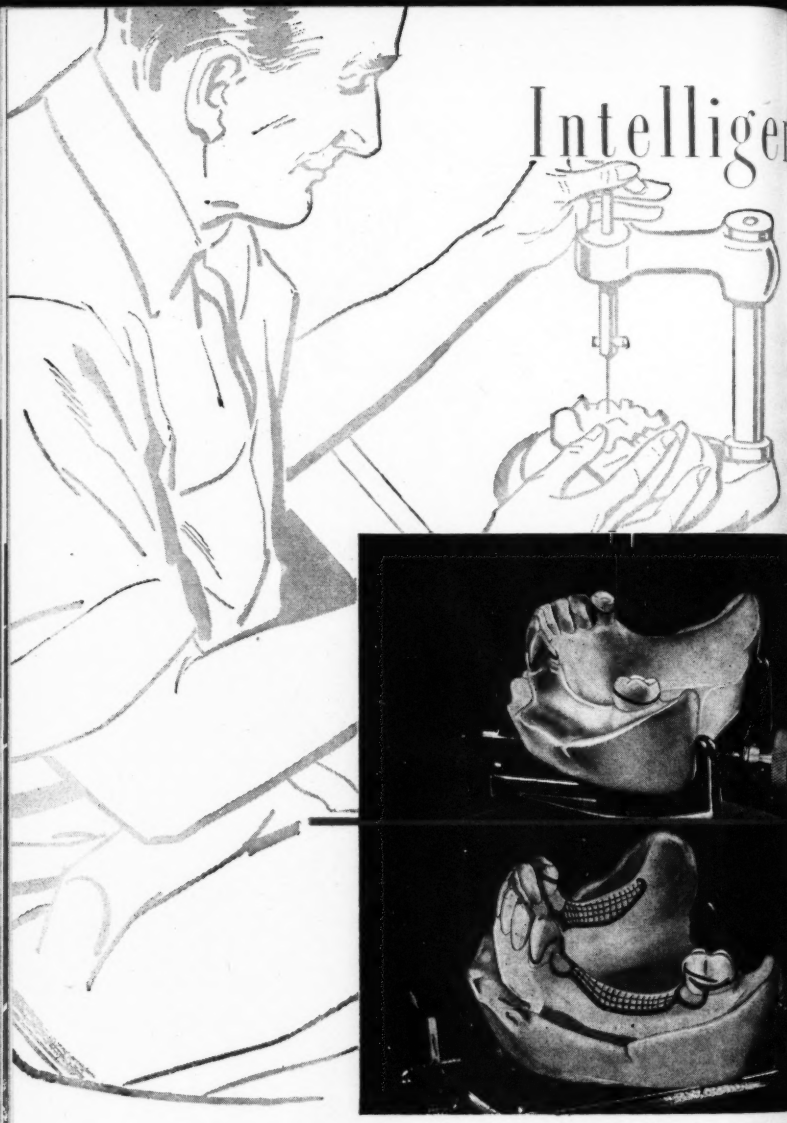

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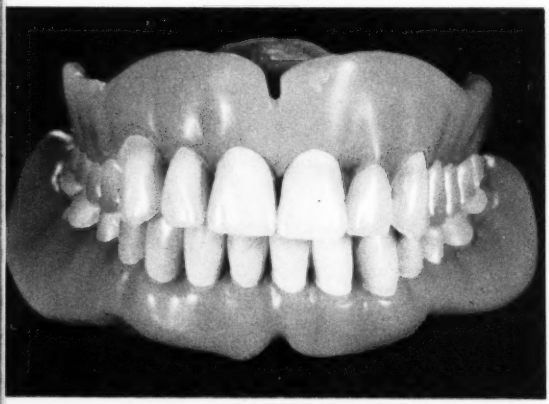
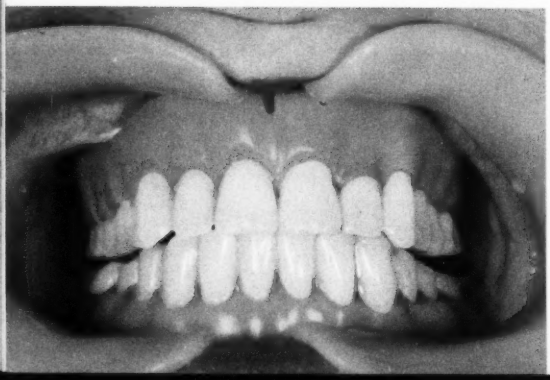


LEFT: An average conventional denture with its monotone appearance of the denture base material and artificial gum contouring.



LEFT: The same denture worn in the mouth of the patient. Completely lacking in any resemblance to a normal healthy dentition, it merely emphasizes the edentulous state of the wearer.

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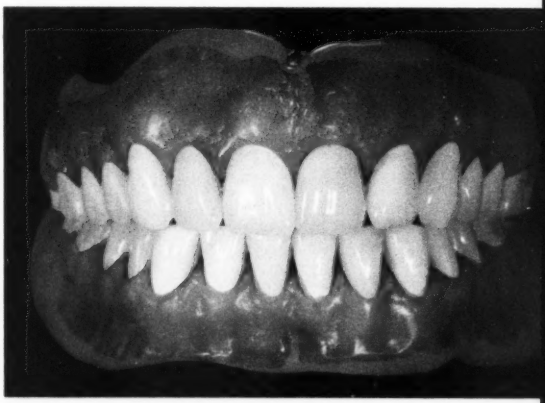
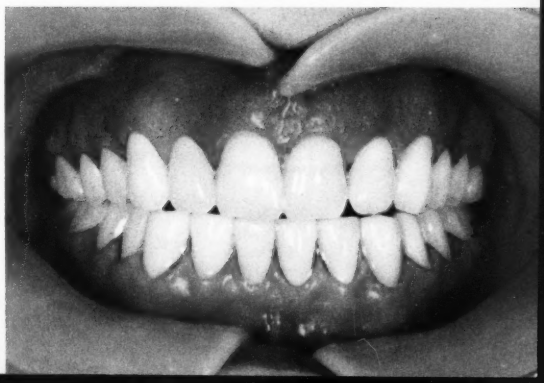


RIGHT: The Trubyte Bioform Veneer Denture made for this same patient presents a striking comparison. Note how the color veneer accurately reproduces the natural color of the living tissue, and the contour veneer supplies the natural anatomy. Trubyte Bioform Mould 21D, staggered in Shades B64 and B66, was used on this case.



RIGHT: The vastly improved esthetics and increased vitality of appearance of this patient presents a striking contrast to the conventional denture shown on the opposite page.

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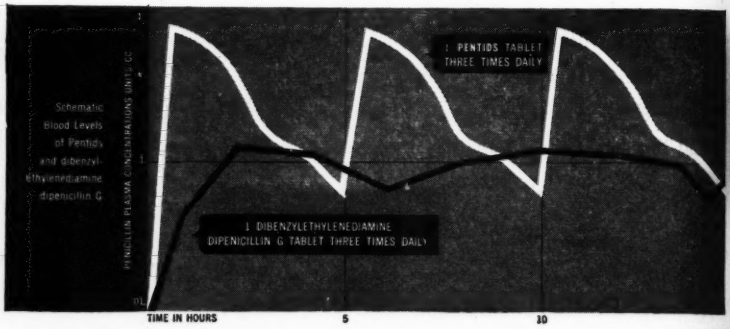

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Picture of the Month

DOCTOR Naomi Coval spends her leisure time attending a parent-child sculpture class at the Brooklyn Museum in New York. The dentist, who is Mrs. Eric Stevens in private life, is pictured above making a model of her eight-year-old son Payson's head, while the boy works on a model of a cardinal. When she was 14, Doctor Coval won a scholarship to the Chicago Art Institute.—*Photograph courtesy of The New York Times.*

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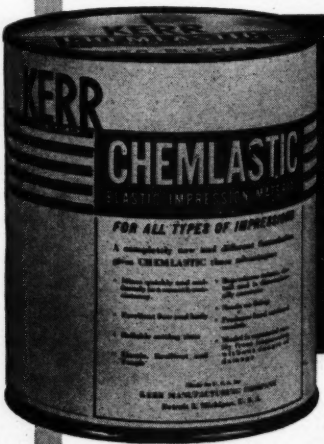

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What Dentists Think About Professional Courtesy

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Dentists interviewed would like to abolish or modify custom.

BY DANIEL S. SCHECHTER

PROFESSIONAL courtesy apparently is here to stay, even though dentists all over the country are in favor of abolishing it. Many dentists privately condemn free treatment or discounts for other practitioners, but they indicate that they conform to this practice.

I recently interviewed in person and by mail 50 dentists throughout the Nation to determine their opinions of professional courtesy. This was the consensus:

1. Dentists today are as busy as they desire to be without giving dental care to colleagues at reduced fees.

2. Dentists who do not bill each other inevitably hesitate to ask for appointments and treatment.

3. Gratis service, unless considered charity, may not be given so painstakingly as service that will be paid for.

Here are some of the typical outspoken criticisms of the extension of professional courtesy. From a Massachusetts practitioner: "Professional courtesy is a polite form of blackmail. I have always preferred the front door. I intend to pay for care given myself and my family, and have. I resent the sense of obligation indicated by taking something for nothing."

A California dentist said, "I think that bad feelings often arise from the courtesy exchange. Good friendship is strained—sometimes lost. I just had a dentist complete all needed work in my mouth. It was understood in the beginning that I would pay cash. I did. He was happy, and I was more than happy. I paid him well, too, and gladly."

An Iowa dentist stated, "I have had other dentists treat me, and when I asked, 'How much?' they just waved their hands indicating that there would be no charge. Later the work proved to be worth just that much. It had been slighted to get me off their hands. The result is that now I have to wear an upper denture."

A practitioner in Washington, D.C., said, "Look around you at all the physicians and their families. You will find so many with such diseased teeth. I know of no professional or business group of such a high intelligence and earning level that has such defective teeth. If they would pay their way, they would have as healthy teeth as our regular paying patients."

A number of interviewees suggested that, when the cooperation of the patient is necessary in therapy, treatment offered without charge might be psychologically less effective. They felt that this was as true if the patient were a dentist or physician as if he were a layman.

Some dentists revealed that they had received "nice gifts" in return for treatment of physician and dentist-patients, but many others felt that giving and receiving gifts had meant nothing but trouble. Most gifts do not cover the loss the practitioner suffers in undertaking treatment of non-paying professional patients. Furthermore, it was felt, gifts are fitting only when a lengthy treatment or a major procedure such as surgery is involved. It would be impractical, interviewees maintained, to present a gift at the time of each office visit. A lament expressed by some dentists was that they could not claim the cost of a gift as a medical expense.

Local Custom

Local custom should be the guide on whether to extend professional courtesy, some dentists suggested. "I would never advise a young dentist to attempt to break local custom," an Alabama practitioner said. "In my city the medical society has voted a 20 per cent discount for dentists but the dental society has no official policy toward physicians; it is up to the relationship of the dentist and the physician. For work on the families of physicians who are not personal friends of mine I give the 20 per cent discount suggested by their own society."

While many dentists recommended that dentists and physicians should pay their regular fees, others suggested that they should pay anywhere from 50 to 80 per cent. Some felt that the question of professional courtesy should depend on the services to be performed. "If it is only a matter of advice and the writing of a prescription, professional courtesy should prevail," said an Illinois dentist, "but if it involves considerable time and effort, the fee should be the same as for lay pa-

tients. In my practice I have at least a dozen dentists, and in taking care of them my fee is calculated on a time plus basis." Another Illinois dentist replied, "I think that two dentists who are good friends should give a discount of 50 per cent on the fee for treatment of each other or of their families, and they should be careful not to ask for service at busy times. If there is no exchange of services, and it is all one way, the discount should be smaller or no discount should be given." A New York City practitioner declared, "I think dentists should be required to pay for medical and dental services for themselves and their families but that they should receive a reasonable discount. The discount would depend either on individual circumstances or it might even become established by custom at about 25 per cent. If a man catered to a large number of dentists, his discount would, of course, have to be smaller than average."

Most respondents asserted that the costs of precious metals and laboratory fees, at least, should be absorbed by the dentist-patient.

Although some dentists indicated that they would make referrals, whenever possible, to dentists or physicians who had given professional courtesy to themselves and their families, they stated that, of course, they would do this only if they had complete faith in the skill of the other practitioner.

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ORAL HYGIENE AWARD

THIS ARTICLE by DANIEL S. SCHECHTER, has won the $100 ORAL HYGIENE award for the best feature published this month.

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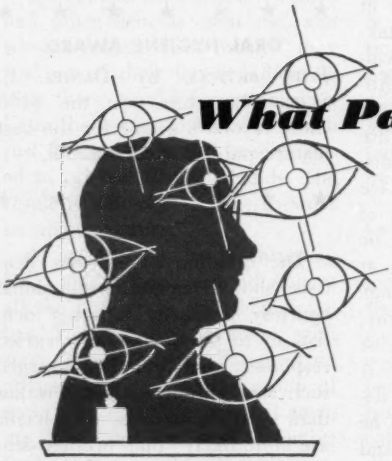
The question of whether dentists should extend professional courtesy primarily to other dentists or to physicians drew varied responses. One practitioner urged such favors for physicians rather than dentists, because physicians are more likely "than brother dentists" to give them referrals. Several dentists saw extension of professional courtesy to their fellows as more desirable. One said, "No discounts are indicated by dentists to physicians because the element of time is too much against us. A general surgeon can do two major operations while a dentist is making one inlay." Another said, "A medical examination may not require the tension and drawn-out procedures—such as preparing crowns, taking impressions, and restoring or adjusting dentures—of a dental visit."

Dentists in all sections of the country would be much happier if the tradition of professional courtesy were forgotten. But what they have called "this irritating ethic" and "this outmoded amenity" seems destined to continue for many years.



What Patients Think of Dentists

BY C. W. GARLEB, D.D.S.

MOST PEOPLE are surprised when they learn that dental students dissect human bodies. This shows that they are unfamiliar with what is required of dentists to learn their exacting profession.

Other indications of people's lack of knowledge about our vocation appear in remarks they make such as, "I do not believe in filling baby teeth." "My roots are wrapped around my jaw bone." "What do you charge for a filling?" "Do you have to cut the gum?" Forgetting about all the sweets their youngsters consume, they inquire, "My children drink lots of milk. Why do they have so many cavities?"

When patients give us diagnoses of their ailments and tell us their dental needs they do not quite trust our knowledge of dentistry. They seem to think we are not capable. For example, patients may say, "I will tell you what I think it is," and then proceed to voice their opinions. "My teeth will not last more than a year longer anyway." "The Army ruined my teeth." "It is an abscess." "How can it be an upper when it hurts in my lower jaw?" These are typical.

Some patients think they should see a physician if their wounds do not stop paining within twelve hours or so after difficult extractions. Some women believe that babies will be marked if teeth are extracted during pregnancy. All this indicates patients' ignorance of dentistry.

Here are some accounts that

Some people think they are doing the practitioner a favor when they come to him for service.

would give us good opportunities to change the false impressions people have about certain matters confronting dentists:

Several patients have told me that they did not think a particular exodontist was as good as his reputation. "Why," said one, "he charged my uncle fifty dollars to pull just one tooth!" This man judged the specialist by his fee alone without considering his great skill or the difficulty of removing a badly impacted tooth. Another man refused to patronize him because, "He made my mother sick when he pulled her teeth." (As if this never happened to other dentists.)

One of my clients complained that the dentist he previously visited "scratched all the lining off my teeth." Some of my prospects go elsewhere because I do not give estimates over the telephone. Others believe that dentists have short hours, low overhead, easy work, substantial incomes, no worries, and early retirement.

It is time that we tell the public the facts. I explain roentgenograms and show patients a human mandible with teeth out to give them a better understanding of how dentists must search for root tips deeply imbedded in unyielding bone and covered by gingival tissue and blood. I show models of various dental appliances and pictures of before-and-after orthodontic cases; before-and-after dentures; cancers; abscesses, and other diseases. This is *not* a waste of time if we want people to really appreciate dentistry as a *precise* and *necessary* science.

Would we gain anything if we informed people about ourselves and our profession? Of course we would. This would put dentistry in the limelight; people would become impressed with our service. It would show them that dentistry is not just an ordinary profession. They would learn that it requires special training and fine skill to give them some special benefits in many ways. Patients must feel that dentistry glamorizes them. They should know enough about our procedures to wonder how we can perform them at such low cost, instead of thinking we sometimes charge too much.

Whenever appropriate we should spend a few minutes informing individuals or groups or larger audiences about our techniques, which cost a small fortune to learn and many years of tedious technical training to master. We must remind prospective patients that not all men and women are qualified to become dentists, that those who lack the mechanical bent, prefer farming and other vocations, or just do not want to go through the

long program, are usually weeded out during the first three months in dental school and left to pursue other careers.

Determination

We must convince people that it takes a strong desire to be a dentist to complete the rigid course that is required. One of my classmates wished desperately to become a dentist, but he hated cadavers. When he neared the hall where dead men grinned at him from dissecting tables he grew weak and pale. Then for three hours every Saturday through an entire school year, while dissecting, he was miserable. He lost many of his meals and much weight but did not quit. He became a good dentist. Only those who are determined to face tough going for years that seem interminable become dentists. Others follow lines of less resistance.

One veteran told me, "I would have enrolled in dental school if I were not getting married." Many feel that way. Others tell me that they would become dentists if they could afford it.

I always tell them that I could not afford it either but did it anyway—that I skipped breakfast for six months because I had no money, waited tables for lunch and dinner and made top grades besides. Before I started to school, I tell them, I worked hard, saved money, remained single because dentistry was my goal.

Dentistry deserves to have its standing raised. With a little self-training a man can learn carpentry, plumbing, car repairing, plastering, cooking, or other trades. Certain skills can be learned by correspondence, but dentistry can be learned only by careful and skillful guidance by trained instructors, in person.

Few people appreciate the full worth of good dentistry. Some patients think they do us a favor by patronizing us instead of thanking us for the wonderful service.

"We thought we would give you a chance," we hear occasionally. And, "So this is your torture chamber." "I want my teeth to fit." "I will pay you five dollars a month." "I did not bring any money because I did not think you would finish today," after being told it would be the last sitting. "We do not know anything about your work but thought you would be good enough just to pull a tooth." "I wish I had my snags back."

I have heard them all, and many more, and none are kind remarks. Small wonder that dentists sometimes lose their patience.

When people realize dentistry's relationship to their health, welfare and appearance, and the long years of toil and trial and error dentists devote to giving them dentistry's personalized benefits, they will become impressed with our profession and value it more.

Each individual patient must be

made to feel a personal interest and pride in his own restorations, dental appliances, handsome, natural-looking dentures or any other work before he can appreciate dentistry's full value.

One of my patients, a school teacher, who admired physicians, once said to me, "Whenever I hear the word surgeon I think of a wonderful man with a halo over his head."

"Dentists are surgeons, too," I reminded her. "Extractions, lancing abscesses, removing tumors, apicoectomies, suturing, and so on are all surgery."

Dentistry's great achievements and how we arrive at them are still secrets to the laity. But from these lines we can learn to publicize our "thunder," I hope, and without exaggerating. When we do, our profession will be elevated.

6408 *Chippewa Street*
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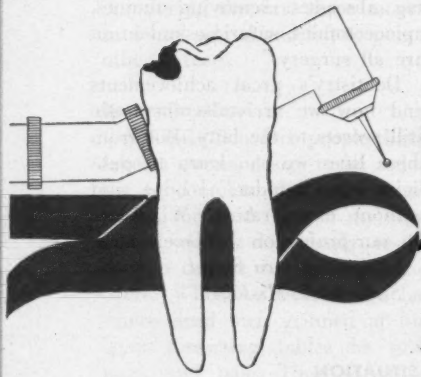
THE MILITARY SITUATION

WE FEEL that it is our duty to advise all the members of the State Society in Priority III, up to 45 years of age, to work out a plan to be followed in the event they are called into one of the branches of the Armed Services. These plans should include a method of disposing of the practice, either by closing the office or having someone else take over during their absence, and if there are any reasons for deferment, they should be checked carefully and so they can be presented to the chairman of the district when either he or our Executive Office advises the individual that he has been selected to be placed on an induction list.

It is our earnest hope that no more dentists over 40 will be called, but if the anticipated need cannot be met by those under 40, then Selective Service will have no alternative but to go into the higher age brackets. During a recent joint meeting of the Council on Federal Dental Services and the Council on Legislation in Washington, estimates on additional dental manpower needed by the Armed Forces for the fiscal year beginning next July were presented. Dental chiefs of the military services estimated that approximately 2,250 new dental officers would be required during the 12 months, including nearly 1,100 for the Air Force, about 700 for the Army and about 450 for the Navy. This total of 2,250 was 375 higher than an earlier estimate made by the Department of Defense. The difference in the two totals was believed to be the result of a higher estimate of need for dental officers in the Air Force. At present, the Department of Defense estimated that there will be 1,400 new dental graduates in addition to approximately 300 dentists in Priority I or II classifications or in the reserves who are now available and acceptable for active duty. These 1,700 dentists will be called first and only after this reservoir of dental manpower has been exhausted will additional Priority III men be called, it is reported.—*Pennsylvania Dental Journal*, June, 1954.



When Should a Tooth Be Extracted?

BY C. SHIELDS

I WOULD welcome your professional answer to a question voiced on several occasions by men and women not unlike the patients who sit in your office chair. The question is simply this: When should a tooth be extracted? Think a moment before hurrying to explain about the extent of decay, condition of root structure, and a patient's physical or oral health.

Seventeen years ago a woman, who was then about twenty-nine, visited a dentist following a long period of dental neglect. The practitioner's examination prompted him to advise his patient to have 18 teeth extracted, which would have necessitated partial upper and lower dentures. She had expected an unpleasant report but not news such as this, so to stall for time in which to recover from the shock she asked, "Do you mind if I take a day or two to think about it?"

Then she promptly called on another dentist, who had an excellent reputation in the community also. His diagnosis almost matched the first. The woman then arranged to see a third practitioner who immediately suggested a series of six one-hour appointments to which the woman agreed. The dentist restored the faulty teeth—without a single extraction.

That was seventeen years ago. Today the woman enjoys excellent health, leads an active life, and what will be of interest to dentists, she still has fifteen of the eighteen teeth that were marked for extraction in 1937. Does this mean that two members of the profession

Author points out cases in which a diagnosis for extraction was reversed to the patient's advantage.

were wrong and one right, or was it just the reverse?

Naturally you would not wish to base your opinion on a single incident such as this, yet the fluctuation of some dental practices can be traced to social lay gatherings where individual dental experiences are recited. Recently in one living room, dentists were divided into two classifications by the host who claimed that older dentists are more inclined to "save teeth" and the younger ones "think only of extractions." He believes that dental schools are currently turning out only potential exodontists.

A young man in the gathering expressed his views through an interesting personal experience. He explained that while in his teens he was struck by a baseball that loosened two lower teeth. He went immediately to a local clinic conducted by a dental school. A student there checked the boy's mouth, felt the loose front teeth, and then called his instructor who promptly mentioned the word extraction. But the youngster demurred, and so did his mother who hurried her son to a neighborhood practitioner. There were no extractions, and the young man who now is about thirty still has the teeth that were struck by the ball. The odd twist in this tale is the fact that the instructor who suggested extraction was graduated in the same class as the practitioner who vetoed the idea, and both are still relatively young. Again, an isolated case of conflicting views cannot be built up to indicate a like division among all practitioners. Or, can it?

These instances offered while soliciting your comments on extractions are cited with the clear understanding that dentistry cannot be considered a science as mathematically exact as the addition of two and two. It is recognized that the variables are too great and too many. Yet it does prompt the thought that perhaps there is some standard of decision that safely eliminates dependence on the practitioner's personal opinion. Although not presented as a question, that is what this is. It is not intended as a suggestion.

This reference to personal judgment recalls the case of a man about forty whose dental history included one important mass extraction. The story must be told third hand because the patient is not available. He died some time ago as the result of a systemic, not a dental, condition even though dentistry did enter the case. While enjoying what appeared to be excellent health, a man was ordered to a hospital when he developed a high temperature that persisted.

Medical investigation and tests pointed to a blood condition as the cause of his difficulty, but corrective measures normally applied in such cases failed to reduce the over one hundred temperature. It was at this point that the physician in charge decided that the patient's seven or eight remaining teeth should be extracted. Incidentally, a lower partial denture used by the man depended on these teeth.

During the weeks the patient ran a high fever his weight slipped slightly, but following the extractions he was reduced to a soft diet and his weight loss increased, while the high temperature persisted. As mentioned earlier, the patient did not survive, and following his death it was rumored that the dentist who handled the extractions acted against his personal and professional judgment. Does this mean that in some instances an extraction is like filling a prescription? Prescriptions are compounded on order without the pharmacist accepting responsibility for their effectiveness.

Considering the comprehensiveness of your professional activities this interest in a single phase of your operations may seem surprising. That is because you may regard an extraction as simply a step toward the correction of a dental difficulty. To the patient it is something else as he realizes that like death there is no retreating from an extraction. It is final.

The artistry of tooth manufacturers and the skill of dental laboratories are available after this "death," but the layman views these as facilities set up to fill a need only when it exists. Publicly he is likely to charge the creation of the need to the dentist even though following an extraction he is inwardly penitent as he remembers and regrets his dental sins.

In mentioning these highlights from some dental histories it is not intended to suggest that they are typical. Probably they are exceptions to common practice, but unfortunately they have provided subject matter for social conversations. At such times someone invariably gets hurt, and in these cases you know who that someone is. Could it be that the practitioners who may not have fared too well during the recitation of the foregoing and similar dental experiences might have prevented this development by offering sound and understandable reasons for their extraction decisions? You know, when you educate a man to your way of thinking you improve the chances of winning him over to your side.

Now, if you wish, you may take over. I am wide open for some educating, especially concerning that question, "When should a tooth be extracted?"

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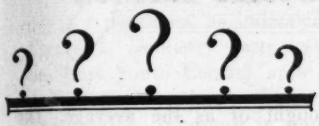


QUIZ CXIX

1. Cancer of the lip is the (a) most common, (b) least common, oral malignancy. _____

2. True or false? Except when swallowing or idly grinding or chewing food, the correct physiologic rest position is maintained by the mandible no matter what the cusp relationship is. _____

3. What is the appearance of osteosclerosis in the roentgenogram? _____

4. With self-polymerizing acrylics a (a) minimal, (b) maximal, amount of monomer that will produce saturation should be used. _____

5. An abscess is a cirumscribed collection of pus in (a) a newly formed cavity, (b) one of the natural body cavities. _____

6. Does xylocaine inhibit the action of antibiotics? _____

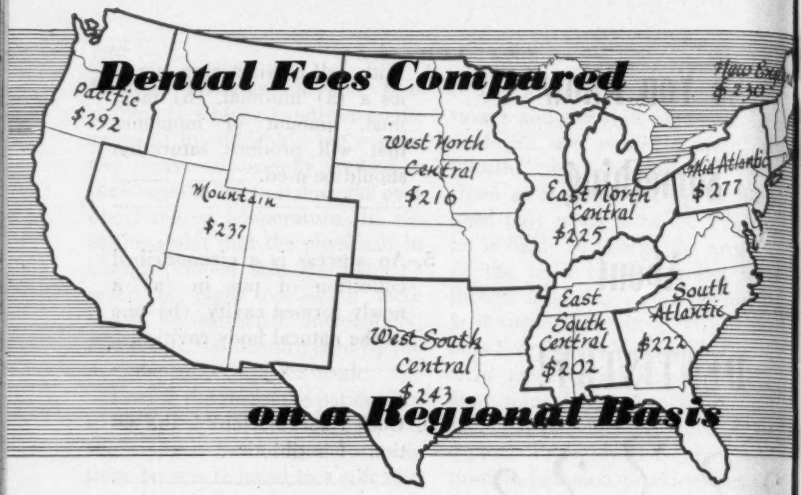
7. In the earlier years of life recession is (a) relatively slow, (b) rapid. _____

8. Does the resistance developed by some organisms to penicillin affect the susceptibility to sulfonamides? _____

9. Most fractures of amalgam are caused by (a) overtrituration, (b) undertrituration, (c) improper cavity preparation. _____

10. True or false? The gaining of arch length to accommodate the deciduous dentition is rarely a problem. _____

FOR CORRECT ANSWERS SEE PAGE 1094



In 1943, Professional Budget Plan made its first national survey of dental fees. A new survey, which was made in 1953, is reported here.[1] Comparisons of dental fees have been made on a regional and on a national basis.

The fees shown are based upon actual charges made by dentists at the time of the installation of the Professional Budget Plan in their offices. Since installations are made in all parts of the country, this survey can be considered as based upon a random sample of sufficient size to make it significant.

As in all Professional Budget Plan studies on fees, the mode has been used as a statistical method of expressing what is popularly thought of as the average. The mode expresses the most common fee and eliminates the influence of the extremely low or extremely high fees. In the case of certain services, the mode will express the average of two common fees for that service. For example, there are two common fees for full mouth roentgenograms—$10 and $15. Because slightly more than half the dentists charge $10 rather than $15, the mode in this case is $12 nationally.

All types of dental service are not covered in this study. Dentures and periodontia treatments have been omitted, because of the variation in techniques, conditions and materials. Nevertheless, the basic operative services have long been the criterion of dental fees. This survey concentrates on these.

For purposes of comparison, a

[1]Dewey, L. C.: A Nationwide Survey of Dental Fees, Budgeteer, Professional Budget Plan, Madison, Wisconsin, (1954).

fairly typical operative case has been used in order to give a graphic picture of what patients in the various regions of the United States probably encounter in estimates of dental services performed by dentists in each region. This typical case takes into consideration the majority of the services covered by the study on fees.

Using a regional map set up by the United States Census Bureau, considerable variation was found in what a patient would have to pay for dentistry, as indicated in Figure 1. Dentistry costs less in the East South Central area and costs the most in the Pacific region. The striking difference in regions is the high level of fees in the Mid-Atlantic states in comparison with neighboring regions. Another interesting fact is the level of fees in the West South Central. Here the region as set up by the U.S. Census Bureau is far from being homogeneous when considered from the economic aspect. The regional level is too low for Texas and too high for Louisiana and Arkansas. The same is true for dental fees.

Professional Budget Plan's typical case would cost $90 more in one area—the Pacific Coast—than it would in Mississippi or Alabama. This amounts to a 44 per cent increase. However, the average family income is roughly 47 per cent more in that western region than in the southern area.

Reasons for regional differences in the level of fees are many. None explain the differences fully. For example, let us compare the ratio of dentists to the population:

Rank in Population per Dentist	Rank in Fee Level
1. Mid-Atlantic 1-1311 Population	2
2. New England 1-1517	5
3. Pacific 1-1571	1
4. West North Central 1-1615	8
5. East North Central 1-1747	6
6. Mountain 1-2309	4
7. South Atlantic 1-3140	7
8. West South Central 1-3293	3
9. East South Central 1-3684	9
United States Average 1-1864	

Apparently the relation of the supply of dentists to the number of patients has little to do with the fee level.

Nationally the level of dental fees according to this survey has increased 83 per cent from 1943 to 1953. In other words, Professional Budget Plan's typical case would have cost the patient $125 in 1943, and today it would be $229. This increase naturally gives rise to speculation as to whether dental fees are high enough to cope with increased office overhead

DENTAL FEES COMPARED ON A REGIONAL BASIS

Figure 1: Chart Showing Modal Fees

By Region for "Typical" Case

	New Eng.	Mid-Atlantic	South Atlantic	E. No. Central	E. So. Central	W. So. Central	W. No. Central	Mountain	Pacific	U.S. Average 1953	U.S. 1951	Average 1943
Total Typical Case	$230	277	222	225	202	243	216	235	292	229	235	125
1—Set F.M. X-ray	10	10	10	10	12	15	10	12	12	12	10	10
1—Proph.	4	6	6	5	4	6	5	5	6	5	5	2
1—Extrac.	4	4	4	4	4	4	4	5	5	4	3	2
1 Porc. Jacket Crown	40	55	45	45	45	45	45	50	60	45	50	25
1 3-unit Posterior Bridge	90	105	75	75	60	75	75	75	105	75	75	45
1 ¾ Gold Crown	30	35	30	30	25	30	25	30	35	28	30	15
2 2-Surf. Gold Inlays	40	50	40	40	40	50	40	40	50	46	50	20
2 2-Surf. Amalgam	12	12	12	16	12	18	12	18	18	14	12	6

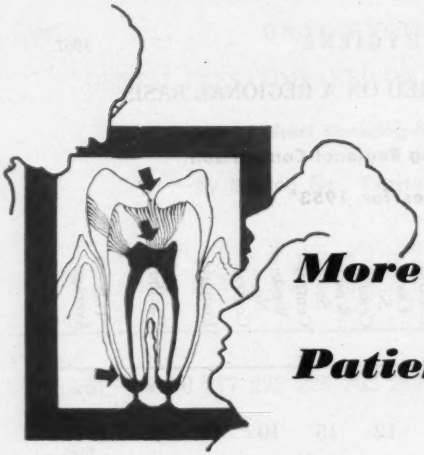
and the present cost of living. At first glance, an 83 per cent increase in fees seems to be a healthy one, but there are other factors to be taken into consideration[1] before dentists can feel overly complacent.

DENTAL FEES COMPARED ON A REGIONAL BASIS

Figure 2: Chart Showing Regional Comparison of Dental Fees for 1953*

	New Eng.	Mid-Atlantic	South Atlantic	East No. Central	East So. Central	West So. Central	West No. Central	Mountain	Pacific	U.S. Average
F. M. X-rays	10	10	10	10	12	15	10	12	12	12
Proph.	4	6	6	5	4	6	5	5	6	5
Extrac. Adult	4	4	4	4	4	4	4	5	6	4
Dec. 2-Surf.	4	4	4	4	4	5	4	4	5	4
Amalgam 2-Surf.	6	6	6	8	6	9	6	9	9	7
Silicates per Surf.	4	6	6	6	5	4	4	6	6	5
G. I. 2-Surf.	20	25	20	20	20	25	20	20	25	23
Full C. Crown	40	35	30	30	30	35	25	30	35	30
¾ Crown	30	35	30	30	25	30	25	30	35	28
Jacket Crown	40	55	45	45	45	45	45	50	60	45
Bridge Per Unit	30	35	25	25	20	25	25	25	35	25

*Survey shows modal fees charged by dentists in 1953 prior to installation of PBP.



More Gratifying Patient Relations

BY EDITH CALMENSON

IN A RECENT editorial, THE STRESSES WE LIVE UNDER[1], it was pointed out that among the traumata to which the practicing dentist is subject in the course of his daily service, is the factor of "blame" from patients, for their dental diseases and the discomforts and difficulties arising therefrom.

This is so patently true that it would seem a logical springboard from which to dive into the *raison d'etre* of this state of affairs, which undermines the health of the practitioner as only a constant irritant can.

It has been found that patients frequently revert to an infantile level when they seek medical or dental care, shedding responsibility onto a father image, who is, in this case, the dentist. Starting from this hypothesis, how can one set about to remedy the situation? It would seem a logical primary step to help the psychologically fledgling patient to become a mature patient in the way that maturity is most often attained, through the recognition of responsibility and responsibility linkage. Harry A. Overstreet in his book, THE MATURE MIND, points out: "Mature responsibility involves both a willing participation . . . and creative participation . . . " He further states: "To mature, in brief, means to accept the fact that human experience is a shared experience, the human predicament, a shared predicament . . . " Therefore, to help the patient adopt a mature attitude and accept responsibility, the dentist must initiate him into the responsibilities of dental treatment, and enlighten him regard-

[1]Editorial, ORAL HYGIENE, 44:338 (March) 1954.

Informed patients serve as anchor of a sound dental practice.

ing the human dentition and the ills to which it may fall prey. Also, the dentist should explain the purposes of treatment and methods of approach.

Thus by enlisting the patient as an ally in the battle for dental health, and through recognition of dental disease as an enemy of both dentist and patient, to be jointly routed by them, the patient is invited to share in the conquest of dental disease on a partnership level. The role of scapegoat is relegated to the appropriate villain —dental disease. If this can be achieved, the dentist can conserve his energies for the basic role at hand, and instead of being an apologist for dental ills, he may step into his rightful role of protector of oral health.

In order to achieve this more relaxed state of affairs, the dentist must be ready to spend some time on the enlightenment of his patients (on the patients' level of understanding) regarding oral functions and the general plan of attack against oral disease. He should stress that this is a common enemy to be met and controlled in collaboration with the patient.

Paradoxically, there may be many dentists, who are eager to ease the tension of their days but may be reluctant to shed the cloak of mysticism that envelopes practitioners of the healing arts. Frequently dentists unconsciously encourage the God-Father image. Many even enter professions to affirm their ego needs, thus fostering that over-dependency and infantilism in their patients that preclude understanding and cooperation.

Therefore, it might be of value to dentists to indulge in some introspection regarding their own psychologic mechanisms, and to evaluate these in terms of ultimate goals and satisfactions. For example, a dentist may find that his ego is more bolstered by an understanding patient's satisfaction with a job well done than by an ill-informed but overly respectful patient's vague and often tenuous allegiance.

It has been said frequently that an informed public is the backbone of a democracy. So, too, may an informed patient be the anchor of a sound dental practice. By letting the facts speak for themselves, the dentist may find a tremendous easing of the tension brought on by over-reliance on ephemeral personality elements, the value of which no one should underestimate, but which, when abetted by more basic properties, can make human relations immeasurably friendlier.

135 *Ocean Avenue*
Brooklyn 25, *New York*

Dentists in the NEWS

Philadelphia (Pennsylvania) Bulletin: A New Jersey dentist, Doctor Luther M. Mkitarian, 500 Warwick Road, Haddonfield, who is a "ham" radio operator, was able to report to a soldier on duty in Germany that his twin brother, formerly stationed on the ill-fated *USS Bennington*, was safe. The dentist was operating his high-powered station early in the morning when he heard a station at Weisbaden, Germany, calling any station near Philadelphia. When none responded, Doctor Mkitarian took the call and talked to an Army sergeant who asked him to call his home in Philadelphia to find out if his brother had been injured in the carrier's explosion.

Chicago (Illinois) Daily News: The Army Surgeon General announced that a new clinical thermometer, which is more accurate and faster than the present mercury type, has been developed by Colonel George T. Perkins. The inventor of the new electronic device, called "Swiftem," is director of the dental division of the Army Medical Service graduate school at Walter Reed Hospital. Colonel Perkins says the instrument can record temperatures by remote control and that it can give readings in five to seven seconds.

Denver (Colorado) Post: A Battle Creek, Michigan, dentist, Doctor Lawrence Walkinshaw, 1703 Wolverine Tower, is considered one of the Nation's leading authorities on cranes. Last spring he took a week-long census of the migratory sandhill cranes along their west-central Nebraska fly-way, accompanied by *Life* magazine photographer Alfred Eisenstaedt. Once during their watch, Doctor Walkinshaw estimated 35,000 cranes along a narrow 20-mile strip adjoining the North Platte River.

Gloucester (Massachusetts) Daily Times: The first award given by the American Society of Dentistry for Children for 1954 was received by John Peter Mercurio, 21½ Church Street, Gloucester, Massachusetts, who was graduated in June from Tufts College Dental School. The award is given to the outstanding graduating student for accomplishment in pedodontic theory, laboratory and clinical interest and practice during his years in school.

Louisville (Kentucky) Courier-Journal: Doctor Howard B. Harris' hobby is traveling to outdoor functions to entertain people with his calliope. The dentist, who practices in Owensboro, Kentucky, once was a musician and actor on a showboat, worked for a circus, and played in John Philip Sousa's band. About nine years ago he acquired the calliope from a circus, renovated it and installed it on a houseboat. Later he sold the boat, mounted the calliope on a circus wagon, and now travels with it to fairs, festivals, parades and other suitable events.

Denver (Colorado) Post: Doctor A. J. Azbill, 454 Spokane Street, Reno, Nevada, has invented a gadget called Shok-Pruf, designed to prevent people sitting on plastic automobile seat covers from getting static electricity shocks when they touch door handles. The dentist makes the parts for his invention

with machines he built himself and hires Reno families to assemble the parts and package the finished products in their own homes.

Council Bluffs (Iowa) Nonpareil: Guest of honor at the 92nd annual session of the Iowa State Dental Society was Doctor Helen Towle of Red Oak, Iowa. She was one of six women in a class of 155 dental students who were graduated from Northwestern University school of dentistry 50 years ago.

Allegan (Michigan) News: Doctor Stewart Miller, 503 Trowbridge Street, has been named city mayor of Allegan.

New York (New York) World-Telegram and Sun: Three young dope addicts were captured by police in the Bronx through the help of a dentist, Doctor Saul Kipper, 1592 Westchester Avenue. The trio had robbed more than a dozen physicians and dentists within three months. When one of the youths came to Doctor Kipper's office for a check-up, the dentist detained him in the dental chair and called police, noticing that he resembled one of the three masked men who had slugged him with a pistol and robbed him of $300 several months before.

Detroit (Michigan) Free Press: Two founders of Delta Sigma Delta dental fraternity, Doctor Charles Weinrich, 94, and Doctor William Cleland, 90, were honored at a special fraternity dinner at the University of Michigan. Doctor Weinrich, who played tennis until he was 85, still practices dentistry in Hammond, Louisiana. Doctor Cleland practiced more than 50 years in Detroit and now lives in North Hollywood, California. About 2,200 undergraduate members of the dental fraternity contributed to pay the cost of transportation for the two dentists to attend. It was the first airplane ride for either of them.

Houston (Texas) Chronicle: A College of Dental Hygiene recently was established at the University of Texas dental school. Director of the college is Miss Nellie G. Robinson, who received a Jesse H. Jones scholarship for study in the field at Columbia University and the F. J. Swanson Achievement Medal for her work there.

Allentown (Pennsylvania) Call-Chronicle: When Doctor A. L. Jenkins, 26 North 14th Street, Allentown, arrived at his home one evening he heard a noise and discovered that someone had entered through a kitchen window. Evidently, he arrived just in time, for the only items missing were ten Allentown Dental Society checks. They could not be passed, the dentist explained, because another official of the society must also sign them.

Chicago (Illinois) Sun-Times: The "stork" that delivered two children to Doctor and Mrs. A. R. Kokes, 9346 South Claremont, Chicago, was an airplane from Ireland. The new arrivals, a boy aged three and a one-year-old girl, have been adopted by the dentist and his wife, who have two other adopted children. Catholic Charities and a priest in Ireland helped them adopt the youngest two after their applications had been turned down by Chicago agencies who told the Kokes that other prospective parents should have a chance.

Awards for items submitted for this month's DENTISTS IN THE NEWS have been sent to:

S. Messinger, D.D.S., 30 Linden Boulevard, Brooklyn, New York
Mildred Cole, 1658 High Street, Denver, Colorado

(*Continued on page* 1072)

A. S. Maki, P. O. Box 1202, Denver 1, Colorado
Colonel William Perry, Rittenhouse Claridge, Philadelphia 3, Pennsylvania
Harriett Shipley, Route 3, Council Bluffs, Iowa
Helen Halbert, 1122 Market Street, Emporia, Kansas
Mrs. H. C. Workman, 400 North Main, Allegan, Michigan

CAN YOU USE A DOLLAR?

TO EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News*, we will send promptly a crisp, new one-dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be returned. When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

THE COVER

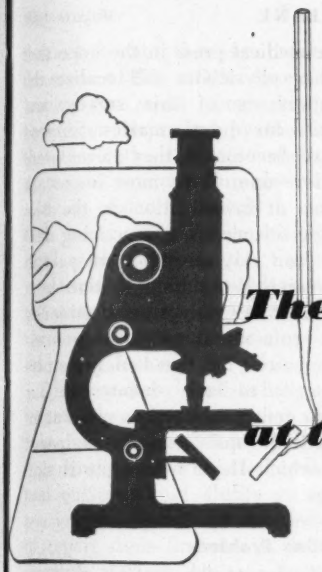
PICTURED on this month's cover is Pikes Peak viewed from Chipita Point, a scenic site on the Rampart Range Road near Colorado Springs, Colorado, where the Colorado State Dental Association will have its annual meeting October 3 to 6. For detailed information about the program and accommodations please address Doctor William Roy Humphrey, Secretary, Colorado State Dental Association, 725 Republic Building, Denver, Colorado.

FLUORIDATION WITHOUT UNDESIRABLE EFFECTS

I HAVE tried to present impartially the evidence for and against the fluoridation of public water supplies. We are justified in believing that it is possible to reduce the incidence of dental caries substantially without any undesirable effects. The fluorine content of water which confers the greatest benefit without harm is known and can be maintained with great accuracy by established methods of dosing. Other vehicles for fluorine have been tested and have all been found wanting. The cost is relatively unimportant.—E. F. W. MACKENZIE, Director of Water Examination, Metropolitan Water Board, London, England.

FLUORIDATION AND IMPAIRED HEALTH

EVEN THOUGH fluorine, like any other poison, exerts a preference for one tissue or one organ over another, it is bound to some extent to affect every one of them. This means interference with their normal function, in other words, impaired health.—LEO SPIRA, M.D., *The Drama of Fluorine.*



The Forgotten Man at the Dental Chair

BY PHILIP PARKER, D.D.S.

General practitioners can play an important role in research if their daily observations are sought.

STEPPING into his bath, Archimedes noted that, as his body was immersed, the water ran over. Rushing naked through the streets, he cried, "Eureka! Eureka!" The interrupted bath of Archimedes is immortal, for he had discovered the method to determine specific gravity.

Today when we think of great discoveries in science we visualize men bending over their microscopes and peering at test-tubes in the white-tile-and-glass-door laboratories. The public also has been sold the idea that it is necessary merely to spend money to get more medical "miracles." This is referred to as the "magic-wand theory of medical advance." The public does not realize that basic research may sometimes go along for decades without accomplishing anything.

I agree with an ORAL HYGIENE editorial entitled THE FLUORIDE BANDWAGON[1] that simple questioning and commonplace observations also constitute research. That being the case, every practicing dentist can play a vital role in dental research especially if, as the edi-

[1]Editorial, The Fluoride Bandwagon, ORAL HYGIENE **43**:1664 (December) 1953.

torial suggests, "we open the channels of communication within the profession."

For several years our dental societies and the boards of health have advocated the use of topical application of fluorides. What has resulted from its use? So far we have had only scattered reports from clinics, orphanages, and other institutions. Why not ask the dentists throughout the country what *they* have observed?

Doctor John O. Percival, a prominent director of research, recently advised his staff, "Get out in the field! Talk with the worker most concerned!"

In the field of dental research that is the equivalent of saying, "Get out and talk with the man at the chair!" That approach would go a long way toward solving some of the problems with which dentistry is concerned. Interviewing some 73,500 dentists is not quite feasible, but why cannot our Council on Dental Research make a survey of *all* dentists on important questions?

The New York Heart Association, in collaboration with the Metropolitan Life Insurance Company and Mount Sinai Hospital of New York City, has undertaken a statistical study of the blood pressure of people who are 65 years of age and over. It was decided to seek the aid of physicians, and a questionnaire card was drawn up and sent to 17,000 practitioners. An appeal has been published in the medical press in the hope that other physicians will realize the importance of this survey and write for questionnaires. Surveys have become as they never were before one of the most important tools of investigation in the biologic sciences. The practicing dentist can play an important part in research if we but question him.

As a rule only a small minority of professional men answer questionnaires, but that is not due necessarily to lack of interest. Our own dental society has sent out an economic questionnaire compared to which Hegel's Absolute is simple.

Define Problem

To insure the greatest cooperation the problem should be defined clearly and stated in as few words as possible. Only in this manner can we obtain replies numerous enough to be statistically significant. All that would be necessary is a return postcard with a simple query such as, "Have you noticed any beneficial effects from the use of topical fluoride?"

The answers to this simple question could be worth more than half a library on the subject. By questioning the men at the chair we at least would initiate a new approach to the many problems that must be solved.

Another way in which dentists can aid research is by furnishing promising leads to the research institutes. Several leads suggest

themselves, but they are beyond the scope of this article. As an example, for years some dentists have been impressed by the fact that the teeth of tobacco chewers are almost immune from decay. If a survey of dentists should disclose that many of them have made similar observations, the Council on Dental Research could pursue the matter further to determine if chewing tobacco contains a caries-inhibiting factor.

I believe many dentists have observed other phenomena that warrant investigation. Many practicing dentists have innate intellectual curiosity and ability to reason inductively but are too modest to report their findings to dental journals. Others hesitate to expound their ideas because at the moment it may not be scientifically popular to think that way. Then there are those who fear that their discovery may be mere happenstance. What is needed is a central clearing house where ideas could be sent for evaluation.

We might follow the example of progressive industrial firms that offer advancement and financial rewards for useful suggestions made by their employees. Today there are an estimated eight thousand suggestion systems in operation, and about one out of every four employee suggestions is accepted. In dentistry all that would be necessary is to offer a suitably inscribed certificate to those who make noteworthy contributions toward advancement of dentistry.

Early in his career the dentist should be taught that it is his duty to pull his oar in the dental research boat at least in so far as cooperating wholeheartedly in field surveys conducted by the council. Research is not an exclusive matter for research institutes. The scientific method is not a matter of atom-smashers and laboratories primarily; it is a way of looking at things. Darwin's work was mostly a matter of observations and descriptions. Our practicing dentists have these qualities in good measure.

Individual Research

The observations made by practitioners need not be of the earth-shaking variety. Many medical discoveries had humble beginnings. Jenner, for example, made his great discovery because he overheard a country girl say "I cannot take the small pox, for I have had the cowpox." Fleming's inspiration came from a tiny bit of mold on one of his slides.

It cannot be stressed too often that some of the greatest medical and dental discoveries were not made by the huge research centers, but by individuals working alone to develop their theories. Beaumont discovered the secret of the digestive process at a lonely fur-trading outpost. Koch was a district physician. McDowell, Long, and Sims were country "doctors"; and surgical anesthesia originated

in a dental office. Some of the most brilliant research has been done by men in limited spheres of action.

Still another way in which dentists can aid research is by examining critically the ideas, facts and interpretations put before them for their acceptance. As a rule dentists believe that it would be impudent to question the exactness of the researches that are printed in the scientific journals. Doctor Edward U. Condon, President of the American Association for the Advancement of Science, declared recently, "The critical questioning attitude is an essential ingredient of the scientific method of working," adding that without such an attitude "the method does not work."

By all means let us have more research by institutes, foundations and universities. The promise in the use of isotopes alone beggars the imagination. But with no diminution of our respect for the labors and efforts of many investigators, it is well to remember that the *in vitro* observations of the man in the research laboratory can never replace the "commonplace observations" of the practicing dentist who sees the "slice of life" —the patient.

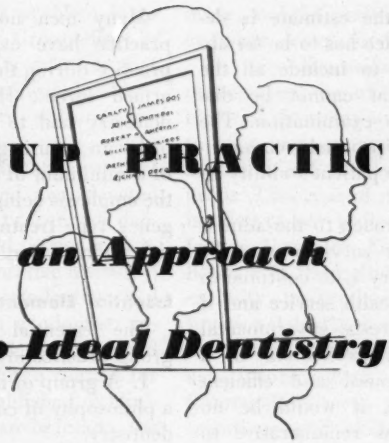
The observations of practicing dentists can be complementary to the basic research of the men in the institutes, and there should be a free interchange of ideas and results. The Council on Dental Research can aid, advise, guide and coordinate. The council cooperates with certain institutions and a few serious investigators, but it underestimates the valuable contributions that can be made by the general practitioner. He seems to be the forgotten man.

Dental research demands the diverse skills of many scientific specialists, but we must not exclude the large number of practicing dentists. They have some of the pieces of the puzzle in their possession. Our body of 73,500 well-trained dentists constitutes a vast reservoir of scientific knowledge that is not being tapped. The problem of enlisting the general practitioner's help in the dental research program is primarily one of opening up the channels of communication with him.

Basic research alone will never solve the everyday problems of the general practitioner. As stated in the Steelman Report, "If knowledge gained from fundamental research proves applicable, it is a by-product rather than an aim." Only by enlisting the aid of the practicing dentist will dental research become purposeful and productive.

As long as dentistry has frontiers, every dentist must turn investigator at each obstacle in his path. Napoleon said that every soldier carries a marshal's baton in his knapsack.

1801 *Marmion Avenue*
Bronx 60, *New York*



GROUP PRACTICE — an Approach to Ideal Dentistry

BY LEONARD V. FOLEY, D.D.S.
ROBERT P. CROW, D.D.S.,
and GERALD E. HALKER, D.D.S.

This plan may make better dental service available to more people and raise practitioners' income.

IN ANY discussion of functional dentistry the principles will be agreed on by all practitioners, but the main objections always are that it is impractical to deliver these services to the average patient. Either the patient cannot afford to pay for complete functional dental service, or the element of time prevents the dentist from rendering ideal dentistry.

It is rather foolish to argue against this practical approach, and it must be agreed that as dentistry is practiced today, rendering an ideal service for a great number of patients is impossible. One person, who has to be a "jack of all trades," receptionist, bookkeeper, nurse, dental surgeon, sales force, laboratory technician, secretary, collection agent and often janitor, cannot be expected to do a thorough job of all. Even auxiliary help for many of these jobs is not the solution. The overhead of an efficient functioning staff puts an overwhelming burden upon the dentist, and his individual production has to be extended to excessive hours and efforts.

Too often in the usual busy dental practice the introduction to dentistry is a half-hearted clinical examination, perhaps supplemented with hastily exposed roentgenograms, the missing units are

counted, and the estimate is determined. The fee has to be set abnormally high to include all the possibilities that cannot be discovered in the examination. The treatment then proceeds, commensurate with the patient's ability to pay.

A fresh approach to the administering of our services must be taken if dentistry is to continue to advance as a health service and if we are able to resist governmental control of our profession. In a properly organized and efficient group practice, it would be no harder nor less remunerative to perform ideal functional dentistry than it is to continue to expend our efforts in the manner just described.

With certain elements of the federal government constantly advocating socialized dentistry and medicine, it behooves the dental profession to seek a way of delivering ideal professional services to great masses of people. Obviously, this cannot be accomplished by the lone operator dentist, so the answer must be sought by combining the talents and energies of a group of dentists. Group practice is not necessarily a revolutionary idea. The advertising dentist employs it to increase his income production, but unfortunately, he violates moral, ethical and technical principles of the profession. Nevertheless, the economy of a group of dentists working together cannot be denied.

Many men now in individual practice have experienced group practice during their service in the armed forces. Here again ideal dentistry had to be sacrificed in order to insure the armed forces of a minimum of dental casualties, the emphasis being placed on emergency type treatment and preventive maintenance.

Essential Elements

The essential elements in a group practice are:

1. A group of men is devoted to a philosophy of complete and ideal dentistry.

2. A physical setup that can accommodate a large volume of patients.

3. Auxiliary help to relieve the professional men of all but their scientific endeavors.

These ingredients, with the proper efficient plan of organization, can deliver ideal dentistry at reasonable fees to many patients.

The pressure exerted by various groups of people for federal control of dental and medical service is not without reason. Dentistry is a necessity of a full life, but dental fees, necessarily, are in the luxury bracket. To effectively combat this situation, dentistry must offer its services at fees that the average and below-average income groups can afford. To further complicate this problem, the average dentist's income is below that which adequately compensates him for his education and efforts. The profes-

sion's most urgent problem is to solve this situation. Group effort in dental practice is a solution that will not throttle the individual dentist's efforts toward self-improvement.

The professional staff must consist of well-qualified men devoted to some specific branch of dentistry. There should be two men in operative and restorative dentistry, a pedodontist, periodontist and prosthodontist. An exodontist, orthodontist and endodontist could be included. A definite routine for each patient is established. A clinical examination can be made, the findings properly noted, a complete history taken, properly exposed roentgenograms and hydrocolloid impressions for diagnostic models completed. (All of these apparent non-productive, time-consuming procedures can be afforded if at the same time the productive elements are being accomplished on other patients by other members of the group.) The models are then mounted on an adjustable articulator, and the sequence of the procedures is outlined. At this time the value of discussion among the members of the group will be apparent. The diagnosis is completed, and the case is ready for presentation. With one man qualified to correlate the elements of the diagnosis after it has been agreed upon by all the members of the staff, the operative sequences can be planned and the fee established. The presentation can then be properly made, and the patient is offered a complete dental service.

In any discussion of practice management one of the basic principles of presentation of services is to offer various methods of treatment that will satisfy the patient's needs. This type of merchandising is alien to our philosophy of professional services, but came about because of the individual dentist's inability to produce the proper functional dentistry at a fee acceptable to the average or below-average income group of patients. Consequently, even the most conscientious and skilled dentist is forced to offer his patients gold or amalgam restorations, hook partials, with a choice of gold or chrome alloy clasps, and full dentures with all-pink as compared to clear-palate cases. From a moral viewpoint, no one can justify this procedure, but the economic whirlpool in which we are caught forces this unsavory condition.

Maintain Standards

Group practice allows dentists to maintain their ideal standards at competitive fees, because the dentist is allowed to assume his rightful role, that of being the guardian and savior of the function of the masticatory organ. With proper diagnosis and presentation of the services the patient can be educated to the necessity of proper masticatory function. He will desire and be able to obtain an oral health service predicated

on the establishment and preservation of function.

For success it is necessary to amalgamate dentists who are well-qualified by experience, both professionally and on the business side of dental practice. A recent graduate can be absorbed by a successful enterprise and carried along until his knowledge and experience are sufficient to uphold his share of the responsibility in the group. However, one well-qualified man who attempts to surround himself with inexperienced talent or desperate, dejected, older practitioners, soon finds that the responsibilities are not shared, but rather piled upon his shoulders. Then, because the income ratios are out of proportion, as soon as the poorly-qualified dentist becomes capable of sharing the burden, he strikes out for himself. The investment in time, trouble and expense is lost.

Successful group effort requires a willingness of the individual to submerge his professional egocentricity for the benefit of the other members in the association. A successful man may be unwilling to exchange his known troubles of individual practice for the possible unknown troubles of a group association. What advantages does he have in entering a group partnership? Primarily, he would be able to practice ethical, functional dentistry, which has been discussed above. Practically, he can have a larger income with less physical and mental strain. He has the advantages of group consultation, adequate auxiliary help, proper physical equipment, volume purchasing savings, proper public relations, paid vacations, income protection, investment and insurance.

Financial Distribution

The problem of financial distribution of the combined incomes of the group is of paramount importance. It is well understood that certain procedures in dental practice produce more income than others. The prosthodontist will be able to contribute a greater share of the gross income than will the specialists in operative service, pedodontics or even crown and bridge. However, by the same token, the prosthodontist will add to the laboratory overhead by a greater proportion than will the services that do not require a laboratory technician.

Another factor that cannot be overlooked is that all phases of general dentistry must be administered to satisfy the needs of the patients. Children, teenagers, parents and grandparents all have dental problems, and it is quite impossible for any dental practice (with the exception of the acknowledged specialties) to morally, and in many cases economically, exist if the less lucrative needs of the patients, such as prophylaxis and operative dentistry, are ignored or dismissed, and only exo-

dontics and prosthodontics are employed.

Part of the solution to the inequalities of income production by the different branches of dentistry lies in the organization and efficiency of the operators. An accurate operator can, by the use of efficient instrumentation and planned procedures, produce an amazing amount of operative dentistry. The ratio of net income between the operative and prosthetic branches of the group is narrowed considerably by efficiency.

Presuming that all the members of the group are of comparable ability, and have contributed an equal investment in the physical assets of the practice, and assume an equal share in the responsibilities and duties in maintaining the practice, it is perfectly equitable to combine the income of the operators and equally divide the net income among the members.

We are practicing in an era of great technical progress. Dentistry has much to offer the public in health and happiness, but our production methods need to be modernized. Group practice offers both the patient and the dentist physical, financial and moral benefits.

999 North Krome Avenue
Homestead, Florida

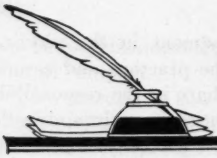
ACCEPTANCE OF THE VALIDITY OF PSYCHOLOGICAL DATA

ALMOST FROM its beginning, scientific medicine has focused its attention on man as an anatomical-physiological-chemical unit. For too many years, the study of human behavior was not included in medical education and practice. Even yet, the medical curriculum includes no courses in physician-oriented psychology, sociology or anthropology. The result is that, in general, physicians have interested themselves in the misbehavior of the stomach and the pancreas, but not in the misbehavior of the total organism in relation to its environment.

Because of the acceptance of the validity of psychological and social data, the psychiatrist investigates all aspects of the total person—physical structure, body chemistry, psychological life, and social relations. These are all interrelated and interdependent parts, so that every reaction to a stimulus, whether it originates within or without the body is a composite of the responses of the various segments of the person.—WILLIAM C. MENNINGER, M.D.

FLUORIDATION AND MOTTLED NAILS

MOTTLING of the nails may occur at any time in life, even at the age of two or three years, long before the teeth become mottled. Whilst there, it indicates that the victim is actually ingesting toxic amounts of fluorine.—LEO SPIRA, M.D., Ph.D., *The Drama of Fluorine.*



EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

LOOK AT THE PROSPECTS FOR WAR !

WHENEVER there are rumbles of war the natural reaction is for each of us to think in terms of his own affairs. Will I be called to military service? Will my family and friends suffer? Will my business be destroyed? Will we experience critical shortages in the things that we need and use?

If the war in Indo-China cannot be contained we are faced with the reality of entering this war through progressive stages: by supplying materiel and military equipment; by air support and naval blockade; by land armies. Once we become committed there is little likelihood of another stalemate such as the Korean War. Neither we nor our enemies were satisfied with that kind of indecisive ending. It is unlikely that the next war will be a comparatively local action. A "little war" is as hard to control as a "little cancer"—both tend to spread and to destroy.

Dentists these days should be taking some stock of their positions should a large scale war threaten. Facing the facts is not warmongering.

Who will be called for military duty? Every dentist now registered under the special Selective Service feature of the "Doctor-Draft Law" would probably be called. We would expect that those dentists who are not yet 50, who are physically qualified, and who have had no previous military service would be called first. Those with some previous military experience who are under 40 would be the next group; those with the shortest service being called first. Dentists holding reserve commissions are always eligible. Those in the higher military grades would not likely be ordered to duty as early as those under the grade of major or lieutenant commander.

If a war comes, the past experience in World War II and in the Korean War should guide the government to prompt action. We would expect immediate controls and freezes on prices, wages, salaries, and rents. Dallying too long before applying controls would set in motion a spiral of inflation that could destroy the economy.

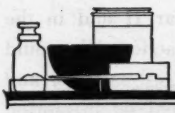
No one likes controls placed on what *he* sells or offers in service. Those placed on activities of the other fellow are not too onerous to bear. A government is slow to invoke economic sanctions because a democratic government is sensitive to the sentiments of voters. Controls are unpopular except with the consumer who is protected. The consumer, when he changes his role to that of a producer wants no restraints. He wishes to be free to command a salary as large as possible and to be allowed to make profits as high as the market will bear. The landlord wishes as rich a return on his property as the traffic will stand.

There are economic ghouls in our country. Unfortunately, in a war economy their spirit of brotherly feeling is destroyed, not only toward the enemy but toward our own people. Profiteering, gouging, and black-marketing are part of a war. Economic controls are necessary.

Dental supplies are not considered to be consumer items. It is not likely that they would be subject to direct controls and price regulation. A war scarcity and short supply of dental materials would come from two sources: government agencies buying more than they need and critical metals being diverted to more direct war uses. There is nothing to make us feel confident that the military would not buy as extravagantly as they have done in wars past. In a future war *more* rather than *less* metals would be required.

This is not a time, neither is there reason for dentists to engage in panic buying or unwise stock-piling or hoarding. The farsighted dentist, however, will look over his equipment and supplies with the view that the Indo-China situation might be the trigger to set off a large-scale war with all that embraces.

Edward J. Ryan



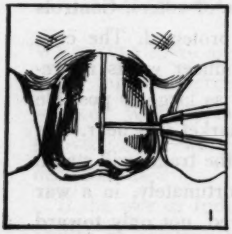
TECHNIQUE of the Month

Originated by W. EARLE CRAIG, D.D.S.

Salvaging a Crown

BY IRVING H. GOLDSTEIN, D.D.S.

Drawings by Dorothy Sterling

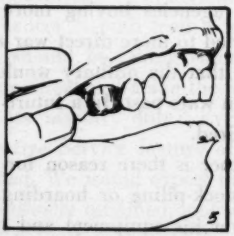


Slice the crown down labial (or buccal) with either carborundum disc or No. 701 bur. Slice may have to extend to occlusal on molars, but may be much shorter on other teeth.

Spring the edges from the margins. (On molar, insert No. 701 bur at occlusal cement line to create space for instrument.) Gently disengage crown from tooth.

Pickle crown to remove cement. Readapt crown with contouring pliers. Try crown on tooth.

Remove crown and insert strip of .001 gauge platinum foil slightly wider than the open cut. Tack to crown with sticky wax. Replace crown on tooth, burnish the foil, and seal the foil to the crown with sticky wax.



Remove crown from tooth. Invest, solder, and polish. Restoration should fit as original crown.

Note to Contributors

We invite dentists to submit material for this page. $10.00 will be paid for each technique used. It is not necessary to make finished drawings—or even sketches—if you explain the procedure clearly, in detail, in your letter. Submit material to:

Technique of the Month,
Oral Hygiene,
1005 Liberty Avenue,
Pittsburgh, Pennsylvania

Editor's Note: A department similar to this one, "Clinical and Laboratory Suggestions," appears each month in Dental Digest.

Q ASK Oral Hygiene A

Please communicate directly with the department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Dilantin Sodium

Q.—I have a patient who has been taking dilantin sodium for 10 or 15 years with no apparent effect on her gingivae until recent months when I noticed a little hypertrophy. She also has pyorrhea. Is there anything further I can do other than frequent prophylaxis? I believe excision has little if any favorable results.

I understand there is a new treatment taking the place of dilantin without the unfavorable reaction on the gingival tissue. Do you know what this new treatment is and its real value? I realize you would not want to prescribe in this particular case, but perhaps you could give me some valuable information.—J.H.S., Colorado.

A.—There are now other treatments for epilepsy than dilantin sodium. One is mesantoin and it is said, "No case on mesantoin has developed hypertrophy of the gingivae or hirsutism. Most of the cases that had developed gingival hypertrophy on dilantin sodium showed a recession of the hypertrophy when mesantoin was substituted."[1]

Frequent prophylaxis seems to be the best local treatment and also thorough brushing by the patient. One of my correspondents wrote me that he had reduced the hypertrophy with zinc chloride, but he did not specify the strength of this drug. However, a 20 per cent solution could be safely used once.—GEORGE R. WARNER.

[1]Kozal, H. L.: Epilepsy Treatment With a New Drug: 3 methyl 5, 5-phenyl-ethyl-hydantoin. Am. J. of Psychology, **103**:154 (September) 1946.

Immediate Dentures

Q.—Your comments in the April ORAL HYGIENE have caused me to wonder what your procedure is concerning immediate dentures. In your immediate denture procedure, do you extract both the upper and lower anterior teeth before inserting the dentures? Do you ever include the extraction of the bicuspid teeth just prior to the insertion of the dentures?—W.F.O., Nebraska.

A.—It is Doctor Smedley's ideal to have all teeth posterior to the cuspids out long enough before the denture is made for the alveolar ridge to be well formed. If most of the posterior teeth have been out for a long time he may put the dentures in soon after the remaining one or two molars or bicuspids have been removed.

The impression or impressions are then made, and when the casts are ready the teeth are cut off and the ridge from cuspid to cuspid shaped up as he would like to have it. When the dentures are completed the teeth are removed and

the bone is trimmed to the shape that the dentures will fit.—GEORGE R. WARNER.

Canker Sores

Q.—I have a young patient, 12 years old, who comes to the office every few months with as many as a half dozen ulcers in her mouth, frequently on the cheek along the lower molar teeth and in the corner of her mouth. They consist of a round greyish patch and are sore. The patient seems normal in every way, and I think she gets a normal diet. Her teeth have a tendency to caries but at present are in good condition.

Will you please tell me what you think causes this condition and a proper treatment for her?—J.N.K., Pennsylvania.

A.—From your description I think your 12-year-old patient is suffering from canker sores. These lesions, in such numbers as you report, are usually caused by food allergy.

We have on record cases such as yours caused by wheat, nuts, eggs, and potatoes. The cause may be determined by the trial and error method of abstaining from one type of food after another. The surest and most sensible way to determine the allergin is by having routine allergy tests made by a physician prepared to make those tests.—GEORGE R. WARNER.

Trigeminal Neuralgia

Q.—I have a patient who has severe tic douloureux on the right side, mostly on the upper lip.

Can you tell me the theory of raising the bite, to offset any pressure on the jaw? Several teeth were extracted at the patient's insistence. Then massive doses of B_{12} were tried. At first there was relief, but now the pain has returned and is more severe than ever. I should like to know if the theory of bite raising has much virtue.—R.A.J., Texas.

A.—As you doubtless know, the cause of trigeminal neuralgia, or tic douloureux, is unknown. But it seems to have been pretty well established that it is not caused by any type of dental dyscrasia. Therefore, raising the bite would probably confer no benefit in your case.

We recently had a case in which the attending neuro-surgeon believed the case, a severe one, was caused by loss of teeth and consequent temporomandibular joint trouble. I x-rayed the joints and found them apparently normal. An alcohol injection was then used, but without much benefit. Finally vitamin B therapy gave the most benefit, and without dentures having been made.—GEORGE R. WARNER.

Thermal Shock

Q.—A young patient, 21 years old, complained that all her teeth were sensitive to heat and cold; the anteriors especially react when she tries to eat fruit. She wants all her teeth extracted. Four years ago she had the same complaint.

The anterior teeth show no abrasion such as the complaint would indicate. Her specific distress was on the left side in the teeth x-rayed because of the cavities. Do you see anything in the roentgenograms to cause this disturbance and a cure for it?—G.A.R., Nebraska.

A.—There are at least two things in the mouth of your 21-year-old

woman patient that may contribute to the sensitiveness of her teeth to thermal shock. The two things I think of are: first the caries, and second the exposure of the necks of the teeth. Citrus fruits have quite a low pH, and their use often results in loss of enamel.[2] There is one other factor that may contribute to the sensitiveness of the teeth and that is occlusal trauma. So many teeth have been lost in this woman's mouth that the remaining ones could quite naturally be under traumatic stresses.

She can probably reduce the sensitiveness of her teeth by using a few drops of glycerine on her toothbrush once a day.—GEORGE R. WARNER.

Dentures for Teenager

Q.—I have a patient 17 years old whose teeth are so defective that I find it impossible to keep them in good condition. Both the parent and son are resigned to dentures. I should like to know whether his age would be a contraindication for dentures and whether they would have to be remade or relined sooner or more often than for an adult.—S.S., New York.

A.—In my opinion this young man would be likely to suffer from rapid and continuous resorption of ridges requiring rebasing or remaking of dentures more often than is the case with the average denture-wearing adult. This would not be because of his age but because the same deficiency in intake or assimilation of bone-building nourishment that has caused the rampant caries of his teeth is likely to also affect the denture-bearing bone.

Before you extract all of this lad's teeth it would be best to put him on a diet free from refined sugar and white flour. Replace these foods with freshly-ground whole grain flour and cereals (preferably from grain grown in Deaf Smith County, Texas) untreated by chemical preservatives, plus whole unpasteurized milk, vegetables and meats in as pure and natural condition as possible, and some vitamins and mineral concentrates.

If the abnormal caries can be corrected through diet, the foundation bone as well as the health generally will improve also.— V. C. SMEDLEY.

Lingual Soreness

Q.—I have a 50-year-old denture patient whose case puzzles me. After wearing acrylic dentures for five years, she developed a sore tongue. The soreness is on one side, from the top along the border to the base. A white patch is present on the middle border of the tongue. She complains of a burning sensation and sometimes a feeling as if she should swallow something that is in her throat. At first I traced the cause to some broken molars on that side and made a new denture for her. She still has the same disorder, so it is not from an irritation. I do not believe she can be sensitive to acrylic compounds unless the sensitivity is a new development.

Could the patient's disturbance be systemic? What would cause these

[2]Stafne, E. C. and Lovestedt, S. R.: Dissolution of Tooth Substance by Lemon Juice, Acid Beverages, and Acids from some other Sources, JADA, May 1, 1947

symptoms? Should I make dentures of another material, or could this be anemia or a fungus infection?

She hints it might be cancer. I tried to tell her not to worry. Lately I have noticed a reddish, sore area near the base of the tongue, and in no connection with the dentures at all.—E.J.D., Wisconsin.

A.—It seems to me, considering the five years of comfort your patient has had with her acrylic dentures, that they are not in causal relationship to the sore on one side of her tongue. This would include the question of allergy, biting the tongue, or roughness of the denture.

Because of the sore being in a relatively small area it does not seem to be a case of glossitis or traceable to systemic origin. Changing the denture bases would not seem to be indicated. And I do not feel that age is related to the trouble, even if she is going through the menopause.

From the foregoing resume of her case it would seem wise to have a dermatologist or oral surgeon see the lesion and give an opinion as to its nature and the desirability of local treatment, Vitamin B treatment, or a biopsy.—GEORGE R. WARNER.

Excessive Saliva

Q.—Lately I received two complaints on upper dentures. The patients complain that saliva gets under the upper dentures. Yet the dentures have perfect suction. In fact, the patients tell me they have no trouble with the denture dropping or any other type of discomfort. I have tried to put an extra seal on the periphery, but it does not help.

I shall appreciate any suggestion you can make.—H.F.C., Pennsylvania.

A.—This excessive flow of saliva is usually an experience of new denture wearers, but in some cases it persists over a long period. These patients complain of the saliva flow being so heavy that they cannot take care of it, but we tell them that the flow is excited by the foreign object in the mouth and that when the nervous system becomes accustomed to the foreign object that the saliva flow will diminish. In the meantime, they should adjust themselves to it.

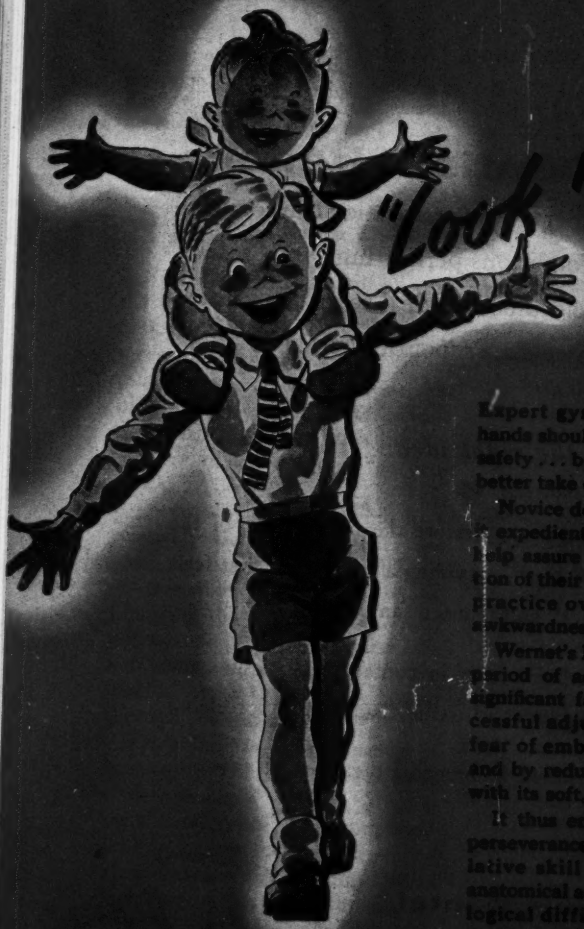
This same reasoning applies to the saliva getting under the upper denture. A denture patient told me today that she has trouble at times with saliva getting under her upper denture, but she disregards and soon forgets it.

A denture patient should be glad of a free flow of saliva instead of a dry mouth, in which case it is difficult to retain an upper denture. —GEORGE R. WARNER.

Trismus

Q.—My patient, a woman 43 years old, complains of intense pain in her left ear when she opens her mouth or yawns. She also complains of a burning sensation on the left lateral border of her tongue. This was cleared up by scaling her teeth and by using hydrogen peroxide as a mouth wash.

This patient has a chronic case of periodontitis and some or all of her



Expert gymnasts might do a ... hands shoulder-carry with comp... safety ... but young amateurs ... better take care!

Novice denture patients, too, ... expedient to take precautions ... help assure the stability and reten... tion of their dentures, until adequate practice overcomes their initial awkwardness.

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WERNET DENTAL LORE

AUGUST 1954

Although the Phoenicians made prosthetic appliances as far back as 1600 B.C., binding loose and artificial teeth in place by gold and silver wires, bands and rivets, and using human and oxen teeth for replacements, it was not until the 17th century that full and partial dentures emerged in recognizable form. It was Anton Nuck, of Leyden, who constructed the earliest recorded full lower denture from a single piece of hippopotamus tusk, in 1680.

• • •

The origin of the use of anesthesia is shrouded in bitter tragedy for the three men who laid claim to its discovery. Horace Wells, a dentist who opened his office at Hartford, Conn. in 1836, and who is generally acknowledged to be the father of modern anesthesia, committed suicide in his cell when arrested on Broadway for committing "annoyances" while under the influence of chloroform. Wm. T. C. Morton, one of his students, who contested his claim, died in abject poverty at the age of 27. And Dr. Jackson, a chemist and physician who also disputed Wells' title to the discovery, became insane and died in an asylum when 33 years old.

• • •

One of the prerequisites for an inventive mind is the ability to make new creative mental associations. This characteristic is well illustrated in Edwin Truman, a London dentist during the reign of Queen Victoria, who had introduced gutta percha as a base for artificial dentures. When engineers were baffled in their search for a covering for the Atlantic Cable that would successfully resist the destructive action of sea-water, Dr. Truman proposed the use of gutta percha! It worked, and he was awarded a government annuity of 1,000 pounds a year for fifty years.

• • •

The first dental license law in the United States was enacted in the State of New York in 1868.

• • •

Although Old Delhi, built in India five thousand years ago, is fascinating to the traveler, the modern visitor finds much of excitement and value in New Delhi, planned in 1911 and completed 18 years later. It is interesting to note that the development of Gum karaya and other products, as significant and profitable exports from India, undoubtedly played an indispensable part in making this modernization possible. Gum karaya is used as the base for Wernet's Powder.

teeth will have to be extracted. She was referred by a physician who said it was a condition that would have to be corrected by a dentist. This condition has existed for two months.

Incidentally, I could not get her mouth opened wide enough to take good impressions.

I shall appreciate any information you can give me in this case.—O.P., Arkansas.

A.—Trismus, from which the patient is suffering, is usually caused by an acute inflammatory condition around one or both temporomandibular joints. This condition can be caused by infection in or around the third molar teeth, an injury from a blow on the face or strain from malocclusion.

Third molars in your case seem to be nonexistent, so far as can be determined from the roentgenograms and casts. However, if the patient cannot give a history of the removal of the third molars, roentgenograms should be made of the third molar regions.

As you say, the periodontal disease in this mouth is quite advanced, so far advanced that some of the teeth are unsalvable. It would be wise, therefore, to clear up this condition by treatment or removal of the teeth that are beyond treatment.

In conjunction with the periodontal treatment occlusal trauma should be relieved; the casts and roentgenograms show that there is occlusal trauma.

It would seem that the subjective symptoms can be cleared up by the foregoing plan of treatment, but acrylic splints may have to be made eventually.

Relief of the pain in the left temporomandibular joint region will be helped, temporarily at least, by the use of hot, moist epsom salt packs.—GEORGE R. WARNER.

SÃO PAULO, BRAZIL, INVITES DENTISTS OF WORLD

IN CELEBRATION of the Four Hundredth Anniversary of the founding of the City of São Paulo, Brazil, four dental congresses will be held simultaneously from October 25 to 30, 1954, in São Paulo. To make arrangements for presenting a table clinic, film, or lecture, and for hotel reservations, please write, before September 1954, to: Sr. Secretario General, Doctor V. P. Delgado F., Caixa Postal 839, São Paulo, Brazil, S.A.

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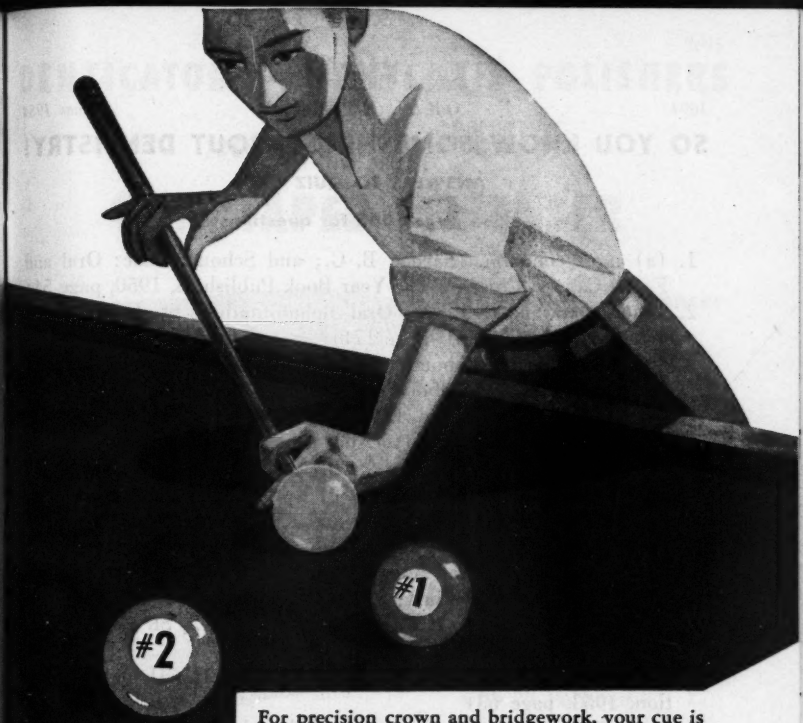

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ANSWERS TO QUIZ CXIX

(See page 1063 for questions)

1. (a) most common. (Sarnat, B. G.; and Schour, Isaac: Oral and Facial Cancer, Chicago, The Year Book Publishers, 1950, page 54)
2. True. (Schweitzer, J. M.: Oral Rehabilitation, St. Louis, C. V. Mosby Company, 1951, page 171)
3. The regions of dense bone are evidenced by increased radiopacity. (Grossman, L. I.: Handbook of Dental Practice, ed. 2, Philadelphia, J. B. Lippincott Company, 1952, page 78)
4. (a) the monomer is the factor that causes shrinkage. (Coy, H. D.; Bear, D. M.; and Kreshoner, S. J.: Autopolymerizing Resin Fillings, JADA **44**:255 [March] 1952)
5. (a) newly formed. (Blair, V. P.; and Ivy, R. H.: Essentials of Oral Surgery, ed. 4, St. Louis, C. V. Mosby Company, 1951, page 78)
6. No. (Dubin, N. L.; and Foner, L. M.: Xylocaine: Report of 3,000 Clinical Cases, J. Oral Surg. **5**:406 [April] 1952)
7. (b) rapid. (Goldman, H. M.: Periodontia, ed. 2, St. Louis, C. V. Mosby Company, 1949, page 32)
8. No. (Accepted Dental Remedies, ed. 18, American Dental Association, 1953, page 63)
9. (c) improper cavity preparation. (Kilpatrick, H. C.: Elimination of Factors Affecting Finish of Amalgam Restorations, D. DIGEST **57**:402 [September] 1951)
10. True. (Speidel, T. D.: Jaw Growth and Tooth Eruption in Their Relation to Space Maintenance, JADA **45**:541 [November] 1952)

FLUORIDATION NOT TO BE FEARED

THOSE WHO fear the use of fluorine should remember that the whole idea of using fluorides for the control of dental caries evolved directly from thirty years of studies on the possible detrimental effects of fluorine, carried out by physicians, biochemists, physical chemists, bacteriologists, nutritionists, public health officials, as well as dentists. In the beginning and over all these thirty years their one problem was the eradication of what was in 1931 proved to be a fluorine toxicosis. We should remember 14 more years of study were carried on with this problem all over the world before the public was asked to accept fluoridation.—M. ARMACOST COX, M.B., *Canadian Dental Association Journal.*

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now in the NEW

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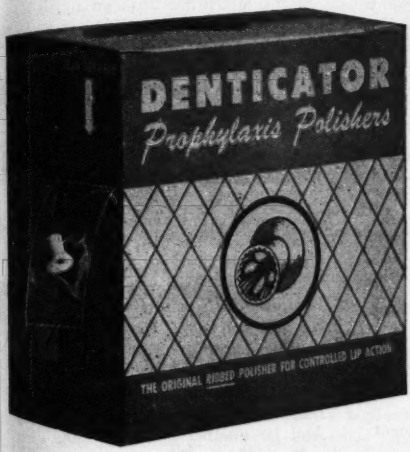

The 1-gross Dispenser containing 144 *Unit* TAPED Prophylaxis Polishers $10.80 complete

Delivers the Polishers from perforated roll, individually wrapped in cellophane—*factory fresh, dust-free.* They have a shelf-life of over *three years.* These are the Polishers that give you "CONTROLLED" LIP ACTION WITHOUT COLLAPSE. *The lip* does the work.

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LAFFODONTIA

A soldier we know lost his heart at the Stage Door Canteen a few nights ago. He knew all about the strict rule that hostesses aren't allowed to make dates with the servicemen they meet at the Canteen. But this lad was persistent. Every few minutes, he'd look down at his pretty partner and say: "Please, miss—please give me your name and address and phone number."

She finally shook her head very decisively: "I just can't."

"Why?"

"It's a civilian secret."

★

"Why did you tie a string to that olive you just ate?"

"How did I know I would like it?"

★

Man: "Did you ever win an argument with your wife?"

Friend: "Yes, once. It was years ago."

Man: "What was it about?"

Friend: "I can't remember exactly. But I do remember very distinctly that we were laying a carpet and her mouth was full of tacks at the time."

★

Co-ed: "I want a pair of bloomers to wear around my gymnasium."

Clerk (absently): "How large is your gymnasium?"

★

"I was so confused I don't know how many times he kissed me."

"What! With the thing going on right under your nose?

★

Boss (to office boy, who is half an hour late): "You should have been here at eight o'clock."

Office Boy (eagerly): "Why, what happened?"

Stop and let the train go by, it
doesn't take a minute;
Your car starts out again, intact,
and, better still, you're in it.

★

Jack and Jill sped up the hill,
A curve up there was sharp,
The car upset, Jack's rolling yet,
While Jill plays on a harp.

★

There was a lad named Willie T8
Who loved a lass called Annie K8.
He asked if she'd be his M8.
But K8 said W8.
His lover for her was very gr8
He told her it was hard to w8
And begged to know at once his F8
But K8 said W8.
Then for a time he grew sed8
But soon he hit a faster G8
And for another girl went str8.
Now K8 can W8.

★

A woman was in Alaska looking over a fox farm. After admiring a beautiful silver specimen, she asked her guide, "Just how many times can the fox be skinned for his fur?"

"Three times, madam," said the guide gravely. "Any more than that would spoil his temper."

★

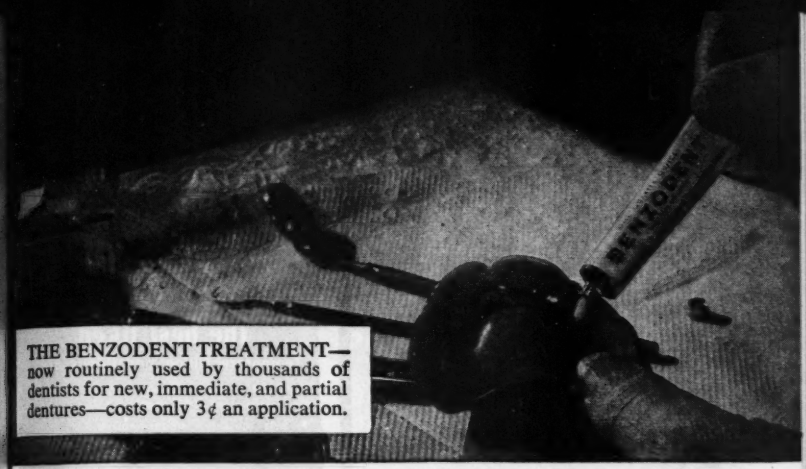
Father to small son: "Never mind how I met your mother—just don't go around whistling."

★

Mrs. Dumleigh: "Tom, I didn't know they had electric refrigerators in the banks."

Tom: "They don't. Where did you get the idea?"

Mrs. Dumleigh: "Well, then how do they get those frozen assets the bankers are always talking about?"



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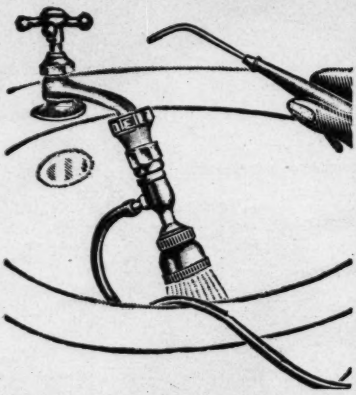

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the best liked
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- Sets quickly, under saliva, over moist medications in wet or dry cavity.
- Box of 4, hermetically sealed tubes.

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Addressed mailing box free on request (straight handpiece, angle or burs).
Standard Contra Angle Rebuilt, $4.85
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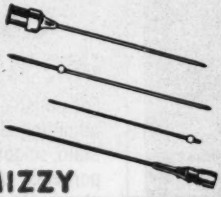

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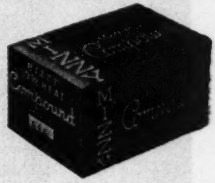

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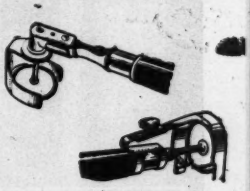

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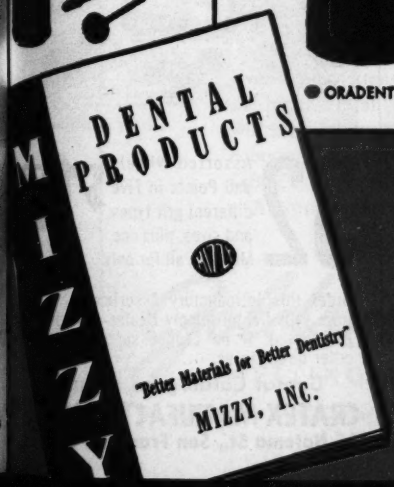

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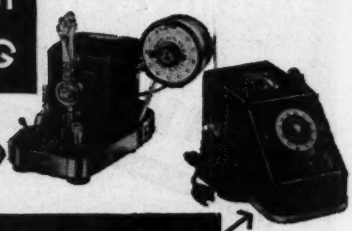
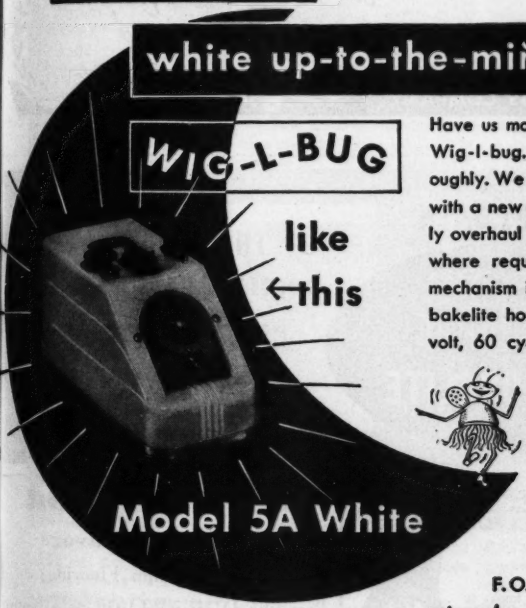


Model 3A → or Model 5A Black

into a bright white up-to-the-minute

WIG-L-BUG



Have us modernize your old Model 3A Wig-l-bug. We check and clean thoroughly. We replace the mechanical timer with a new electric timer. We completely overhaul the motor, supply new wires where required. And we remount the mechanism in a beautiful, bright, white bakelite housing. This offer only to 110 volt, 60 cycle machines . . . Costs only $27.50, F.O.B. Factory.

You can turn your Model 5A Black Wig-l-bug into a Model 5A WHITE by simply changing the housing...or having your dealer salesman do it for you. White Case only $10.00, F.O.B. Factory. If Black Case is returned a credit of $5.00 is allowed against above price.

At present the change-over from Model 3A to 5A White takes about 10 days. If you don't have a Wig-l-bug, you can order one for prompt shipment, Black $55.50, White $60.50.

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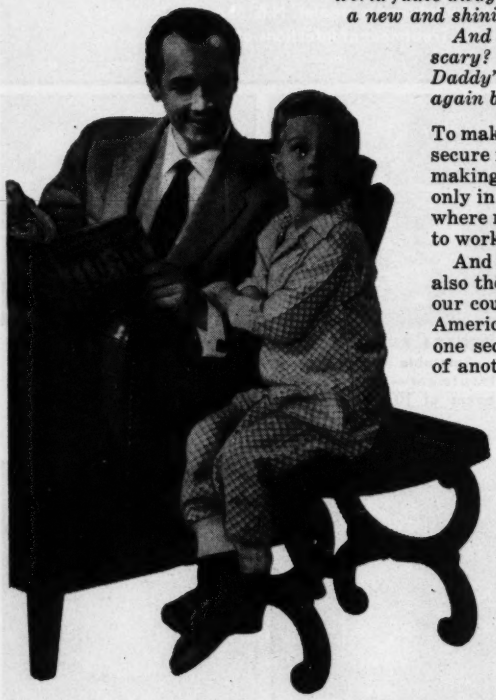
"then the dragon came..."

Nobody tells a story like Daddy. The everyday world fades away as his words lead you into a new and shining land.

And what if the Dragon is a bit scary? You need only climb into Daddy's arms to be safe and secure again before it's time to sleep.



To make those we love safe and secure is the very core of homemaking. It is a privilege known only in a country such as ours, where men and women are free to work for it.

And taking care of our own is also the way we best take care of our country. For the strength of America is simply the strength of one secure home touching that of another.

Saving for security is easy! Here's a savings system that really works—the Payroll Savings Plan for investing in United States Savings Bonds.

Go to your company's pay office, choose the amount you want to save. That money will be set aside for you before you even draw your pay. And invested in U.S. Savings Bonds which are turned over to you.

If you can save only $3.75 a week on the Plan, in 9 years and 8 months you will have $2,137.30. For your sake, and your family's, too, how about signing up today? Or, if you are self-employed, join the convenient Bond-A-Month Plan where you bank. Start saving this easy way today!

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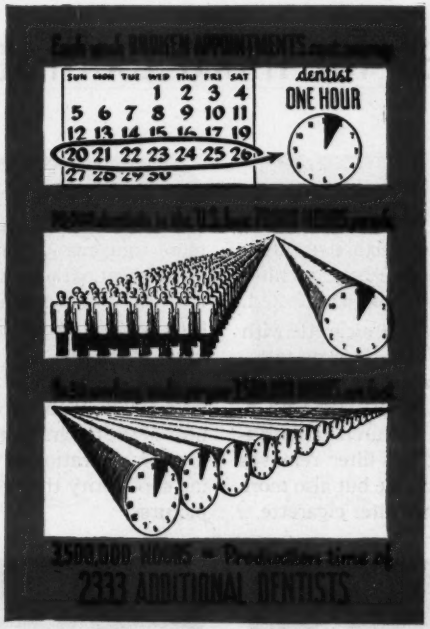

(Actual Size)

This small but *effective* chart is again available by popular demand. It had been out-of-print until recently but dentists have been asking for it—and it is ready for immediate delivery.

Broken appointments are always a perplexing problem. At least *some* of the problem can be overcome by using the *Broken Appointment* chart regularly. It is ideal for reception room use and for enclosure with monthly statements.

The price — only $3.50 for 100 charts.

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☐ Send me 100 *Broken Appointment* charts as illustrated above. I enclose $3.50. (If you prefer billing through your dealer mention his name below please).

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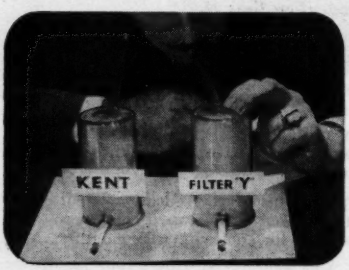
Here's proof that Kent's removes far more teeth-staining

AFTER YEARS of experiment and research, a new cigarette with a flavor that really pleases and a filter that really works has been perfected.

It is the new KENT cigarette with the Micronite Filter. Recent tests, made by well-established methods in the laboratories of P. Lorillard Co. and two outside research organizations, show that this filter removes not only more nicotine but also more *tars* than any other filter cigarette.

Because KENT removes so much more tars, many dentists have reported that patients who smoke only KENTs have less tobacco stains on their teeth than patients who smoke other cigarettes.

Each week on the television program, "The Web," Jonathan Blake, host of the program, gives the amazing demonstration of KENT's filtering superiority that you see in these pictures.



3. Into one, he draws smoke from the new KENT. Then he fills the other glass with smoke from another well-known filter-tip brand cigarette . . .

4. After allowing time for the nicotine and tar particles to settle, Blake lifts up the glasses to show what has happened . . .

For full smoking pleasure . . . plus proof of greatest health protection ever.

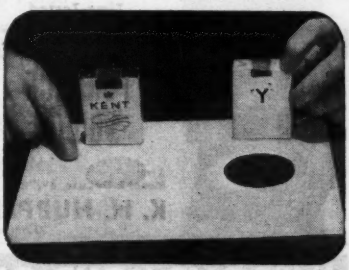
Kent

MICRONITE Filter tars!

1. Blake puts a sheet of ordinary white paper on a table, saying, "I'm going to prove that KENT's Micronite Filter really works."

2. On the paper, Blake puts two special glasses made with tubes through which he can draw smoke inside each glass . . .

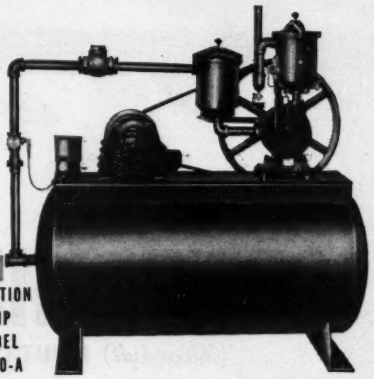
5. See! A harsh stain from the irritants in the smoke of the other filter cigarette . . . scarcely a trace from the smoke of the new KENT!



6. Here's proof you can see, Doctor, that KENT removes far more nicotine and tars than any other filter cigarette you can buy.

with exclusive MICRONITE Filter

central suction



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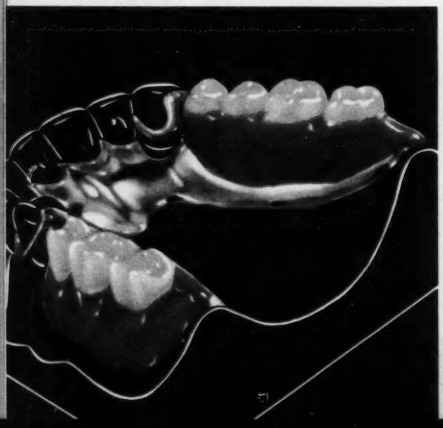

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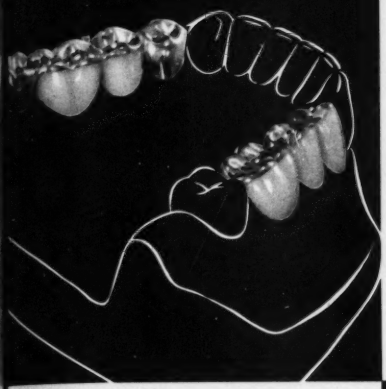
Again you save at Warren! Where your case calls for an upper plastic partial with bent wire clasps, Warren suggests the cast horseshoe skeleton plus two clasps, posterior teeth and plastic saddles—complete, for no more than you'd pay elsewhere for an ordinary plastic partial.



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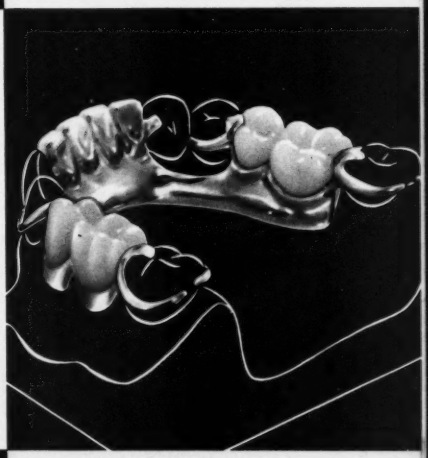

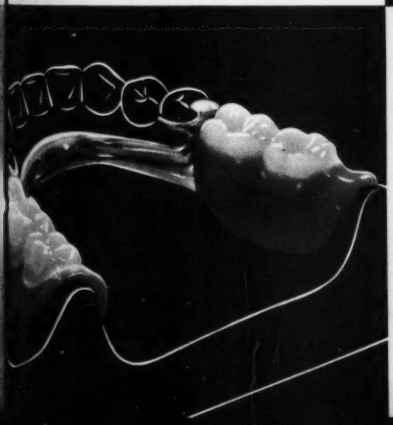

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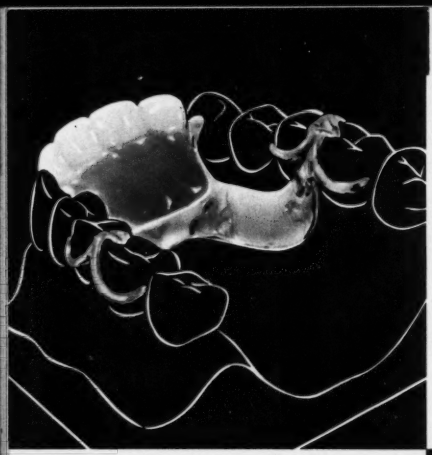
Another instance of better work at less cost! Where you'd normally use an all-plastic partial with bent wire clasps, Warren offers this lingual bar with plastic saddles, and any type posterior teeth—complete, a far superior case that doesn't cost you a penny more.



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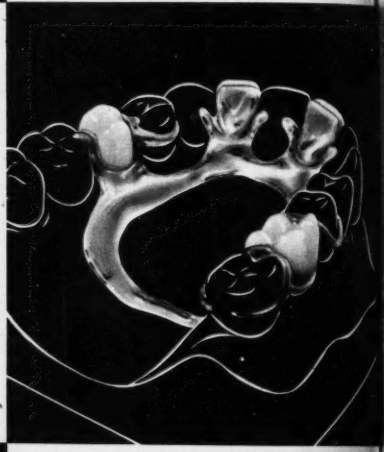
Horseshoe with anterior teeth

In *all* BICAST cases you get the added bonus of cast gold clasps for the same price you'd normally pay for all-metal or skeleton cases and 30% less than all-metal or skeleton gold castings.

BICAST

Palatal bar with circular bar with additional units

Pay no more for this *patented* gold and chrome case than you'd normally pay for an all-metal partial made of nationally-advertised chrome cobalt alloy. Get the rigidity of the chrome base plus the resiliency of gold clasps at 30% less than the cost of an all-gold casting, whether it be all metal or skeleton.



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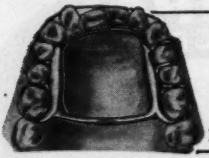

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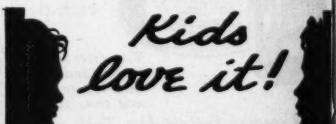

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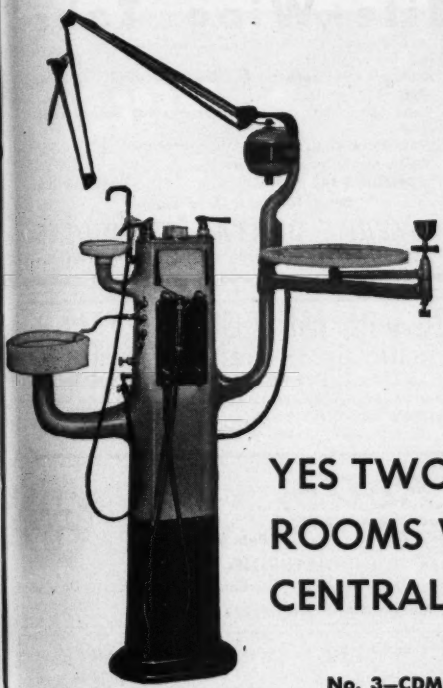

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(For Plastic Dentures)

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Tru-Rugae was the first departure from a machine shop finish on partial dentures. When Ticonium introduced Tru-Rugae a new age of partial denture prothesis was established. Tru-Rugae dentures are now being made better than ever before.

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a practicing dentist developed Astring-o-sol® the concentrated mouthwash

Here is a peppy, invigorating mouth rinse that not only tastes good and sweetens the breath, but also loosens and flushes away organic debris, and helps protect tissues of the mouth and gums.

Astring-o-sol is an efficient detergent and effective deodorant. It is mildly astringent, will not injure delicate oral tissues, and is ideal for daily mouth care. It is economical because it is concentrated . . . you use *drops* rather than *drams*.

Use it at the chair
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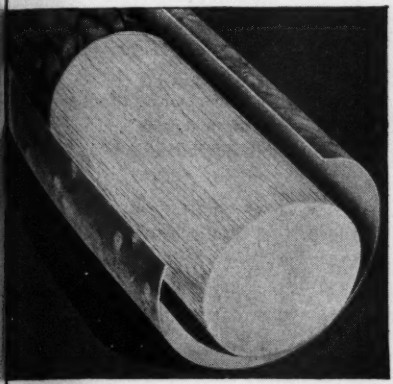
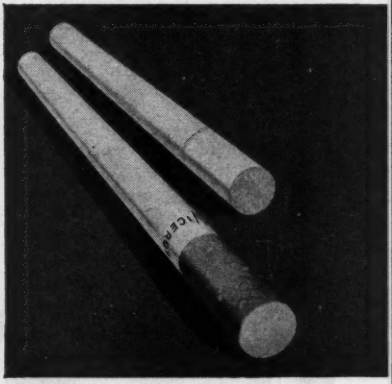
"Which Cigarette Shall I Choose?"

...REMEMBER THAT NEW VICEROY GIVES SMOKERS

DOUBLE THE FILTERING ACTION!





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The smoke is also filtered through Viceroy's extra length of rich, costly tobaccos. Thus Viceroy actually gives smokers *double the filtering action* . . . to double the pleasure and contentment of *tobacco at its best!*

ONLY A PENNY OR TWO MORE
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Filter Tip VICEROY

OUTSELLS ALL OTHER FILTER TIP CIGARETTES COMBINED

hi!

Any moment, now, it will happen . . . a little hand reaching . . . a puppy-tail wagging . . . and suddenly a boy and his new dog will be tumbling together in the beginning of love.

Here, in such a moment, out of the heart's deep need for love begins the reaching for security that all of us need all our lives.

Only in the freedom of a country like ours can each one of us have the privilege of working for the security of those we love. And building that security yields a double reward: happiness in our homes and strength for America.

For the strength of our country is simply that of one secure home joined to another's.

Your security and that of your country begin in *your* home.

Saving for security is easy! Here's a savings system that really works—the Payroll Savings Plan for investing in United States Savings Bonds.

Go to your company's pay office, choose the amount you want to save. That money will be set aside for you before you even draw your pay. And invested in U.S. Savings Bonds which are turned over to you.

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High concentration possible. Result: more brilliant radiographs.

Less staining fingers and clothing.

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Over six years have elapsed since the first "Sevriton" Fillings were placed in the mouth. And since this time a wealth of data on "Sevriton's" performance has been gathered. This data all points up to one important fact: "Sevriton"— if used properly — differs from all other plastic filling materials in that it's color stable, it assures marginal adaptation through controlled shrinkage and it's well tolerated by the vital tooth. These basic qualities make "Sevriton" *superior in every way.*

To insure your SUCCESS with "SEVRITON" Fillings just follow these simple hints:

1 — Flow it, don't pack it.

"Sevriton" is most easily handled when used in a flowing consisten — just as it begins to grow sluggish. Using "Sevriton" in this st also assures proper density and homogeneity of the finished filli

2 — Use Non-Pressure Technique.

Where practical, use a matrix to control the directional flow "Sevriton" Filling. In other cases, such as cervical cavities, use pressure technique . . . flow liquid "Sevriton" into cavity, harden and then remove excess filling material with a finishin or disc.

3 — Application of Cavity Seal.

"Sevriton" Cavity Seal controls shrinkage and insures marginal tation. Since it's not a mere insulating varnish, it should be sparingly to cavity surfaces — including marginal edges — imm before inserting the filling.

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ONE OF THE AMALGAMATED DENTAL GROUP OF COMPANIES

"where oozing from a vascular bed is anticipated"*

ADRENOSEM stops capillary bleeding and oozing. Adrenosem acts directly on the capillary walls to increase resistance and decrease permeability.

There are no reported toxic effects or contraindications attributable to Adrenosem. Adrenosem does not affect blood components or induce embolus formation. It has no sympathomimetic or vasoconstrictive action. Adrenosem is compatible with vitamin K, heparin, and commonly used anesthetics. (It is suggested, however, that antihistamines be withheld for 48 hours prior to and during Adrenosem therapy since antihistamines tend to inactivate Adrenosem.)

*Sherber, D. A.: The Control of Bleeding, Am. J. Surg. *86*:331 (Sept.) 1953.

Adrenosem

the missing link in the control of bleeding

The therapeutic regimen for Adrenosem is *simple* and *safe:*

- *preoperatively* to control oozing during surgery and provide clearer operative field: one to two ampuls (5 to 10 mg.) every two hours prior to surgery for two doses.
- *postoperatively* to prevent hemorrhage and check oozing: one to two ampuls (5 to 10 mg.) every two hours until there is no indication of undue bleeding. To maintain control, one ampul may be administered every three hours or 1 to 5 mg. orally t. i. d.
- to control *active bleeding:* One ampul (5 mg.) every two hours until bleeding is controlled; frequency of dose may then be diminished.
- to control *severe bleeding:* one ampul (5 mg.) every hour for three doses; then every three hours until bleeding is controlled.
- to control *mild, low-grade bleeding:* 1 ampul (5 mg.) every three or four hours until bleeding is controlled; then 1 to 5 mg. orally four to five times daily until bleeding ceases.
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- *pediatric dosage:* up to four years of age — 1 mg. intramuscularly or orally with same frequency as for adults, until bleeding is controlled. From four to twelve years of age — ½ the adult dosage as indicated.

Available as Ampuls: 5 mg., 1cc. (package of 5).
Tablets: 1 mg. S. C. Orange, bottles of 50.
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for Children 2 thru 6 years

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Avoids Lost Time

Designed by a child's specialist *for real convenience and chairtime conservation.* Fits over back of adult chairs: Ritter, SSW, Weber and Harvard *in a matter of seconds!* Raises child off seat, maintains position for dentistry including x-rays of lower molar area. Makes child comfortable. Has own arm support and foot rest. No sliding forward.

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...for patients who require supervised treatment

When the need for more effective interproximal hygiene and stimulation is indicated, the Oral B Stimulator can be very helpful. Under the supervision of a dentist, this carefully designed instrument may be used in conjunction with periodontal treatment as well as for routine daily home care.

You will notice that tips are of durable Neoprene, a material which is uniformly flexible and cannot deteriorate like rubber. Their triangular shape is also important because it fits interproximal spaces more effectively.

Send for a professional sample of the Oral B Stimulator and test it yourself!

WRITE TODAY

for a supply of convenient prescription pads prepared for the many doctors and hygienists who wish to prescribe the Oral B.

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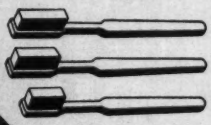
Oral B TOOTHBRUSHES



Oral B 60
Oral B 40
Oral B 30

ORAL B COMPANY
448 SO. MARKET ST.
SAN JOSE, CALIF.

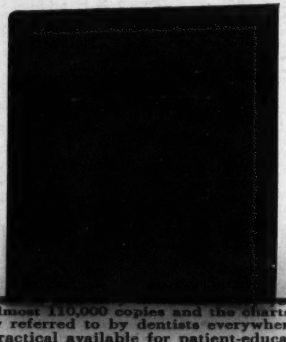
"I have in my office a booklet published by you in 1940, called 'Visual Education in Dentistry.' I have used this booklet so frequently that it is completely worn out. Can you tell me where I can get another like it or similar to it? I shall be very grateful for this information." --Missouri

"Kindly send me several more copies of 'Visual Education in Dentistry' for the education of the back-woods people I serve in my country office. A few copies of this book, given to teachers, will do a great deal of good. These charts will do more than books to educate the layman." --New York

"Will you please send me the booklet, 'Visual Education in Dentistry,' designed to explain dentistry to patients? I have very religiously consulted this booklet at the office of my dentist, and find it so instructive that I believe it should be a requisite in my home."--California

"Please send ten copies of 'Visual Education in Dentistry.' I place these booklets in the reception room and many mothers request copies. I believe you would have a heavy demand if this idea were promoted." --Indiana

"Last week I received your booklet, 'Visual Ed- ... be congratulated. Next week I am giving part of



These comments are the* RULE *...Rather than the exception

almost 110,000 copies and the charts are commonly referred to by dentists everywhere as the most practical available for patient-education purposes.

Comments

● "I recently saw a copy of Visual Education in Dentistry and thought it

"Last week I received your booklet, 'Visual Education in Dentistry.' It should be congratulated. Next week I am giving part of my time to a group health program and I would like to have two or three more copies." --Maryland

"Please send a copy of 'Visual Education in Dentistry.' Ours is so reception-room-used that a replacement is necessary." --Illinois

"'Visual Education in Dentistry' has proved popular here at the School of Medicine." --New York

"Will you please send me a copy of your very fine booklet, 'Visual Education in Dentistry.' It was recommended to us by Professional Budget Plan." --Minnesota

the exception

almost 110,000 copies and the charts are commonly referred to by dentists everywhere as the most practical available for patient-education purposes. *The charts are ideal for dental patients of all ages.*

We are also receiving an increasing number of orders from school teachers in the elementary and high schools—teachers who find *Visual Education in Dentistry* a valuable aid in their dental health class work.

We refer you to the comment from the dentist from Indiana (upper left). He is giving copies of *Visual Education in Dentistry* to mothers who request it. He believes this idea should be expanded.

The potential value of this series of 31 charts (many printed in full color) to dentists, to teachers for use in dental health class work, and to mothers and fathers for use in the home is unlimited. Do you have one or more copies in your office?

The price is only $1.50 to Dental Digest subscribers. We refer the special combination offer (see coupon) to nonsubscribers. A better investment could not be made.

Comments

● "I recently saw a copy of Visual Education in Dentistry and thought it to be quite interesting. I am opening my office February 3 and I believe that such a booklet would be valuable in showing my patients various phases of dental pathology, and efficacies of proper dental restorative work." **Chicago.**

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● "Please send me your booklet, Visual Education in Dentistry. I have the ninth edition and have about worn it out. I couldn't do without it." **Muskogee.**

● "I received a copy of Visual Education in Dentistry today and am very pleased with it. Several of the illustrations are just what I have been looking for. I intend to frame some. Since this would destroy the book would it be possible to get two more copies?" **Randolph.**

Dental Digest, 1005 Liberty Avenue, Pittsburgh 22, Pa.

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☐ Please enter my name on the basis of eight issues of Dental Digest and a copy of Visual Education in Dentistry for $4.00.

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*Denture Base Capillarity**. .

Some surfaces form a stronger attachment for the mucus film overlying the mucosa than do others. This principle was first discovered and applied in practice by Dresch Laboratories. The tissue bearing side of each Dresch-Built denture is treated to possess the maximum capillarity so as to have the best retention.

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Why not send your next several cases to Dresch—and compare the greater value in patient satisfaction. The Dresch Laboratories Company, 1009 Jackson St., Toledo 1, Ohio.

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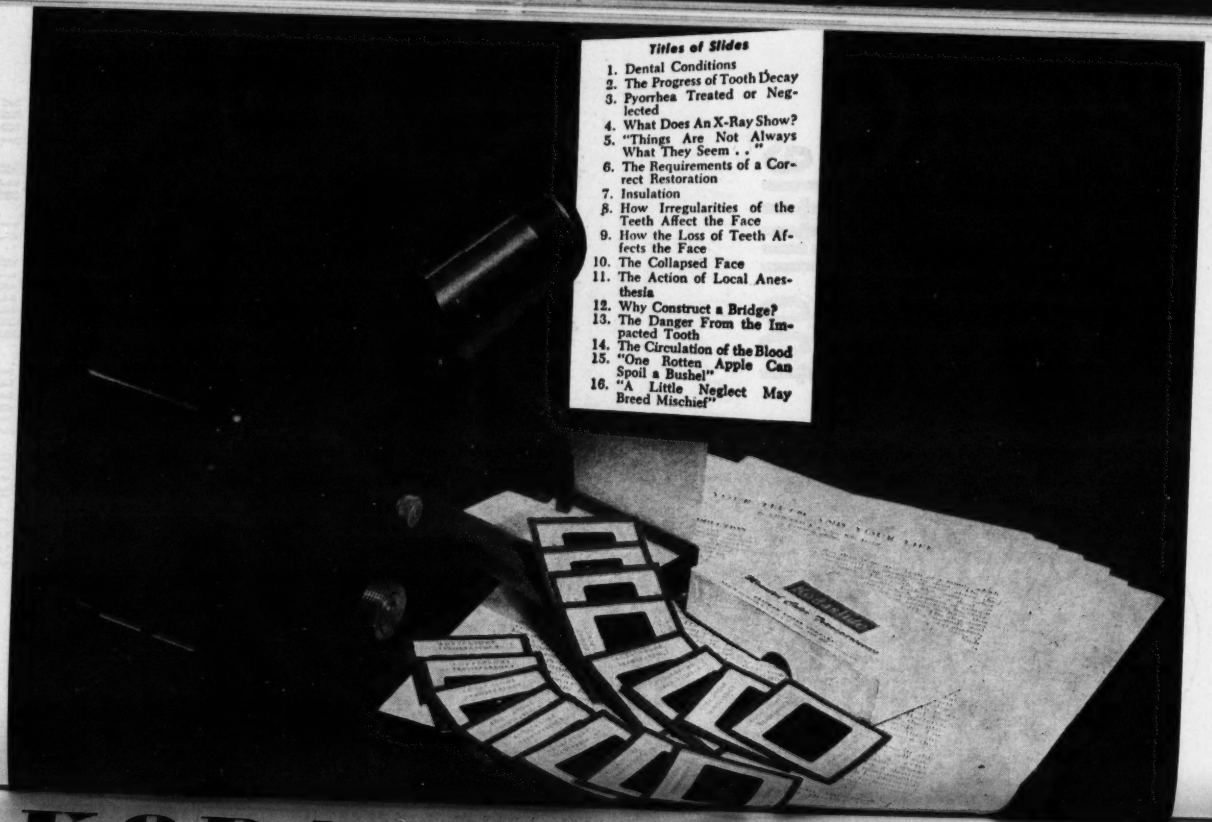
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2. The Progress of Tooth Decay
3. Pyorrhea Treated or Neglected
4. What Does An X-Ray Show?
5. "Things Are Not Always What They Seem . . "
6. The Requirements of a Correct Restoration
7. Insulation
8. How Irregularities of the Teeth Affect the Face
9. How the Loss of Teeth Affects the Face
10. The Collapsed Face
11. The Action of Local Anesthesia
12. Why Construct a Bridge?
13. The Danger From the Impacted Tooth
14. The Circulation of the Blood
15. "One Rotten Apple Can Spoil a Bushel"
16. "A Little Neglect May Breed Mischief"

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KODACHROME *Slides*

. . . ideal for patient-education and lecture purposes

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We feel that you will find the KODACHROME slides most effective for use at the chair, in explaining dental conditions to patients in language they understand. In addition, the slides are proving to be invaluable to dental societies, dental instructors, and clinicians. The coupon is for your convenience in obtaining your set *now.*

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10c per word, initials and figures used each counting as one word. Please send remittance with your order.

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A dentist tells us — "I have never had a patient complain of 'tired teeth' with a G-3 partial. Its resiliency makes all the difference. After years in the mouth, too, there is no sign of the tooth and tissue destruction which I see with other materials."

To find out why G-3 saves abutment teeth, write for our illustrated booklet, "NEY-ORO G-3."

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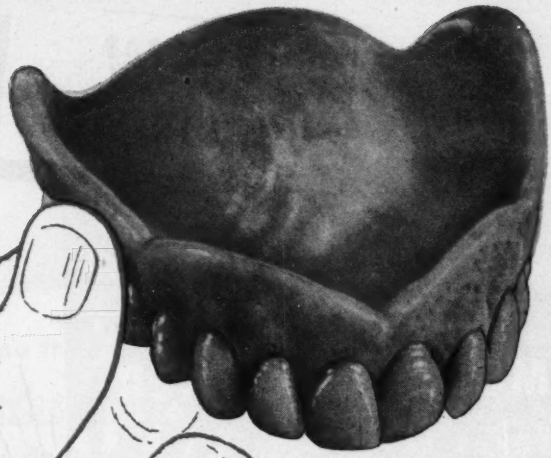
ADVERTISING INDEX

WHO'S WHO AND WHERE

Although we aim for accuracy in this index, last-minute changes often alter page numbers and positions.



make it REAL — make it *Realist!*

DOCTOR, your denture patient deserves the finest restoration available. Upon his satisfaction with his denture rests your professional reputation.

To assure your patient of that satisfaction, give him a denture that will keep his secret, the most natural looking denture in the world, a Vernonite Realist denture. Realist duplicates Nature right from the jar — there's no need for hand staining or painting of the finished case.

It is scientifically mixed and blended at the factory under controlled conditions to assure perfect consistency and perfect coloration. It makes stronger, harder, better-fitting dentures as well as the most natural looking.

On your next denture case, specify Vernonite Realist Gel . . . make your dentures "real" — make them of Realist!

Specify VERNONITE® *Realist* GEL

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It might prove an eye-opener . . . to examine your dentures six months after your patients have been using them — cleaning them . . .

Cleaning—ah, there's the rub! Because if they've been rubbing too hard, with abrasive cleansers and harsh brushes, what had been a thing of beauty may now well be a cause for professional dismay.

Instruct your patients in the Polident gentle "soak-and-rinse" method — the method that floats away debris, removes stains, and destroys odors, without injury to delicately fitted ridges and high polish. Let Polident help your patients pass the "six-months-after" test with sparkling clean dentures.

Generous supply of office samples free on request

HUDSON PRODUCTS, JERSEY CITY 2, N.J.

Dept. C-84

POLIDENT

Recommended by more dentists than any other denture cleanser

IPANA® A.C.

FOR TRIPLE ORAL ACTION

1

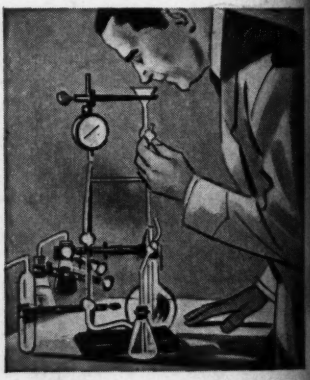
Fights Caries with AMMONIATED formula, which provides the proved decay-fighting action of urea and dibasic ammonium phosphate.

2

Combats Mouth Odors with CHLOROPHYLLIN, universally recognized for its powerful deodorant effect.

3

Cleanses Beautifully with SYNTHETIC DETERGENT, better than soap, and TRI-CALCIUM PHOSPHATE, an effective polishing agent.



Osmometer studies were done on 50 patients who had definite halitosis. *All* were free from unpleasant mouth odor for four hours or more after brushing with IPANA A.C.

IPANA A.C. is pleasantly flavored with essential oils and saccharin, a non acid-producing, sweetening agent.

IPANA AMMONIATED CHLOROPHYLL Tooth Paste

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